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ABSTRACT

This course text outlines the objectives and content for a professional continuing education course on patient education for the hospital librarian. Topics covered include: (1) definition of terms; (2) national studies and surveys; (3) compliance issues; (4) patient/learner motivation; (5) elements of a successful program; (6) role definition; (7) legal mandates; (8) the concept of informed consent; (9) current awareness resources; (10) learner characteristics; (11) pedagogy versus andragogy; (12) physical considerations of learners; (13) examples of health education programs; (14) librarian roles; (15) wellness and self-care programs; (16) planning models; (17) needs assessment; (18) goal setting; (19) selection of methodologies; (20) program delivery; (21) evaluation; (22) costs and reimbursement; (23) library cost considerations; (24) materials selection; (25) organization and control of materials; and (26) copyright concerns and acquisition. References and recommended readings are listed at the end of each chapter. (MES)

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CE 636

PATIENT EDUCATION

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Course Description

This course text has been prepared as an introduction and guide to patient education for the hospital librarian. Topics will include: a working definition of patient education; mandates, benchmarks and rationales; characteristics of learner groups; identification of resources and program exemplars; cost considerations; planning models; and selection and organization of program materials.

Course Objectives

At the conclusion of this course, participants should be able to:

1. Define patient health education as a planned program of educational activities aimed at involving the patient in his/her own health care.
2. Identify major legal, consumer, and professional rationales for the delivery of health education materials to the lay public.
3. Compare the differences between the learning needs of different age groups.
4. Identify major health information resources available for providing information to the lay public.
5. Identify five major steps in program models and verbalize the librarians' role in three.
6. Identify materials selection criteria and describe the reviewal process and resources most appropriate to the participant's work setting.

AKCNOWLEDGEMENT

This course text could not have been attempted, much less compiled, without the help of numerous librarians who gave information, encouragement and criticism. Hopefully, this product can further a much needed dialogue.

Any presumption that even one of the topics presented be fully addressed is most intimidating. At best such a course text can give just enough information and direction to allow the already motivated student to move ahead a bit.

Particular thanks is extended to Logan Ludwig, Julie Quain and Doris Rickards, three colleagues who have contributed much with their encouragement, ideas and labor.

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CHAPTER I.

A. Overview

1. Basic definitions provide a common vocabulary for all practitioners in the area of health education.
2. Patient education, unlike consumer information, is defined by the site and situation in which it occurs.
3. Fragmentation of patient education efforts remains a major concern.
4. Factors of the "Health Belief Model" must be identified to facilitate program planning.
5. Examples of on-going programs provide insight into successful application of theory and research.

B. Definitions

At-risk role - behaviors undertaken by a person who feels well but knows that one or more risk factors exists.

Compliance - "the extent to which the patient's behavior (in terms of taking medications, following diets or executing other life style changes) coincides with the clinical prescription." (Sackett and Hayes)

Patient education - those health experiences designed to influence learning that occur as a person receives preventive diagnostic, therapeutic and/or rehabilitative services. (Joint Commission of Health Education Terminology)

Patient education - a process of growth in an individual which increases his/her ability to make informed decisions about his/her health as a result of planned educational activities.

Health - a state of complete physical, mental and social well-being and not merely the absence of disease. (World Health Organization)

Health behavior - "any activity undertaken by a person who believes himself to be healthy, for the purpose of preventing disease or detecting disease in an asymptomatic stage". (Kasl and Cobb)

Health belief model - a model derived from motivation theory which demonstrates the interrelationship between core beliefs and health outcomes. The factors contributing to compliance are:

1. general motivations regarding health
2. perception of vulnerability and of value of illness threat reduction
3. perception that compliant behavior will lower threat

Variables such as continuity of physician care, family support and prior experience become modifying factors.

Health education - "a process that bridges a gap between health information and health practices" or "guiding individuals or groups to perceive given healthful actions as being in line with their own values and goals" (Somers)

Illness behavior - "any activity undertaken by a person who feels ill, for the purpose of defining the state of his health and of discovering a suitable remedy". (Kasl and Cobb)

Sick role behavior - "activity undertaken by those who consider themselves ill, for the purpose of getting well". (Kasl)

C. National Studies and Surveys

Patient education is a planned, documented process which is distinguished from consumer education in part by the place or situation in which it occurs. Unlike consumer education, patient education also involves documentation in the patient's care record. Patient education has been characterized to an unfortunate degree by a high level of fragmentation.

In 1975, and again in 1978 under a contract from HEW's Bureau of Health Education, the American Hospital Association surveyed U.S. community hospitals. Patient education was defined as "educational activities with written goals and objectives for the patient and/or family during inpatient hospitalization." A 1972 AHA study using the same definition had indicated that 15 percent of respondents had patient education programs. Three years later 46.4 percent of respondents indicated they had at least one program. The surge in activity had been rapid, fragmented and resulted in an explosion of new program tools.

Eleven regional meetings with hospital representatives were held to corroborate the 1975 survey findings. Information resources and significant needs of librarians in health care settings who wish to explore their role in patient education were identified as follows:

1. The availability of education support and patient education resources varies from region to region, from state to state, and from hospital to hospital.
2. Hospitals are just beginning to coordinate patient education activities on a total hospital basis.
3. The majority of persons designated as patient education coordinators are in the department of nursing or education, with responsibilities for staff development. Most would like to gain skills in education, management and evaluation.
4. Many patient education programs have already been developed for disease specific areas.

5. Historical data are available on patient education programs through documentation in medical records.

A major concern of the survey was the identification of persons responsible for patient education and what time allocations are made for that purpose. Forty-five percent of the respondents were able to place responsibility in a specific department. Regardless of hospital size, nursing was the most frequently cited department. Of those respondents identifying a department, 84.6 percent reported a specific person/position responsible for coordination. Only 13.9 percent were full time patient education coordinators.

An overall patient education policy was cited by 12.7 percent of respondents. Where a policy existed it was intended to emphasize hospital support for, and staff commitment to patient education. It also was intended to help insure a consistent measurable approach to the task. A committee to generate and monitor patient education policy was used by 17.2 percent. Most likely members were nurses (93.7 percent), physicians (71.8 percent), and administrators (57.3 percent).

Among the many significant points and recommendations made as a result of the AHA survey, the following bear special mention:

1. A multi-departmental committee is a mechanism that can be used to gain cooperation and involvement as well as assistance in program planning, development, implementation, and evaluation.
2. There is a need for educational programs that will assist those responsible for coordinating patient education to develop skills which will help them to carry out their responsibilities.
3. For hospital care-givers to carry out patient education responsibilities, they must feel comfortable with the information and skills needed.

While the numbers have improved, the situation remains essentially the same. Unfortunately the economics of the 1980s may preclude sufficient assignment of resources to further improve the situation.

Obviously the level of involvement and support any library can offer will vary greatly from setting to setting, but serving on a multi-departmental committee to identify priority needs of care-givers is a legitimate point of entry into the field. Knowing current practice will only partially prepare a librarian to participate in the delivery of planned programs of patient education. Because resources are always limited, and allocation decisions must often take into account future program needs, it is imperative that librarians have some sense of future concerns and initiatives.

D. Compliance Issue

There are additional factors to be considered in planning patient education programs, which are indicated by the "Health Belief Model". The desirability of the outcome (compliance) must be addressed. Patient

compliance has become a "hot" issue in patient health education. From the beginning, the term "compliance" has troubled some concerned persons. Horace Ogden, Director of the Bureau of Health Education, in an address on "Patient Education - The Federal Perspective" said:

The very term "patient" implies a passive, bowed, and sort of submissive attitude. Compliance. We've talked about achieving compliance. That's a hell of a word. None of us wants to be compliant. We want to be collaborative. We want to take part in our health care. And I think those words reveal a mind set, which runs through generations of a hierarchy, and I think we've got to start turning that around. The terms "Professional" and "layman" relate back to religious origins, clergy and the layman, which meant that one obviously was in touch with God, and the other wasn't. "Patients" are becoming impatient and "laymen" don't want to just lay there.

David Sackett in his introduction to Compliance with Therapeutic Regimens defines compliance as "The extent to which the patient's behavior (in terms of taking medications, following diets or executing other life-style changes) coincides with the clinical prescription."

Accepting the negative connotations and discarding the two alternative terms "adherence" and "therapeutic alliance", compliance was accepted as defining the extent to which a patient yields to health instructions and advice, however generated. "Compliance" was the term of choice because it also suggests rigorous observation and evaluation -- important factors in assessing patient health education.

Sackett offers some words of caution worth noting. Compliance need not indicate success. If the diagnosis is incorrect, compliance can be total -- and totally futile or disastrous. If the therapeutic regimen complied with does no more good than harm, compliance is again a hollow victory. The proposed therapy, and the diagnosis, must be substantive to make compliance valid. Finally, unless it can be documented that the patient is a willing and informed participant, the behavior changes cannot be considered compliance.

Sackett and Haynes provide what many regard as a definitive overview of compliance indexed both by disease entity and by strategies tested for improving compliance. A librarian who is aware of the health education initiatives in a given setting, and who is also aware of compliance issues and resources can be quite valuable to program planners.

To forestall the rash thought that compliance studies might single-handedly validate patient education, several caveats were delivered by Victor Neufeld in his chapter "Patient Education: a Critique".

1. Knowledge of condition suffered a very low correlation with patient compliance. Knowledge without attitudinal change seems of little value, but attitudinal change is not always incorporated as an education goal.

2. Probably only a few clinical conditions really lend themselves to compliance studies if one agrees that compliance is only validated where the treatment is demonstrated to be significantly effective. Research to identify which conditions are best suited is needed.
3. Most compliance studies do not accommodate tracking or explaining unexpected behavior such as dropping out of a program. A real concern with the dropout must be "has the patient's level of anxiety increased as a result of partial or partially understood information?"¹

A final concern must be with the cost-effectiveness of compliance. For some patients, achieving clinically significant compliance is impossible because of unrealistic dollar or personal costs.

From a pilot study with hypertensives several generalizations can be drawn with regard to predicting adherence to therapeutic regimen.² First, self-reports of adherence were positively correlated with lowered blood pressure. Second, the patients who were most knowledgeable about their regimens had the lowest blood pressures. (Merely knowing about the nature of high blood pressure and its control was ineffective). Third, patients who perceived non-adherence as having the most serious consequences were the most adherent. One obvious conclusion to be drawn from this is that the nature of information given patients is quite important. Apparently, the more specific the information with regard to the individual's regimen, the more likely it is to enhance adherence. This, as will be discussed later, is in keeping with current knowledge of how adults learn.

A major factor influencing adherence with regimens which was explored in the pilot study is social support. A cautious summary of the finding would indicate that where high self-esteem is coupled with social support of the spouse, adherence is greatest. Surely this suggests close scrutiny of the role of information outreach programs for the family as well as the patient.

Perhaps related to self-esteem as a factor in compliance or adherence is body image.³ A research study with adults having clinical diagnosis of acute or probable myocardial infarction indicated that the more favorably a patient views body parts and functions, the more value he places on caring for himself and the more compliant he becomes. This suggests that library/health education materials that aid in understanding and appreciating the body may contribute to increased compliance with therapeutic regimens.

Materials such as Man: the Incredible Machine which emphasize the wonder and beauty of the body seem perfectly suited for all but the youngest patients.⁴

John Knowles speaks to the value of threat reduction. In discussing the course of human disease and wellness over the last few hundred years he says that very little of the improved health status of mankind can be attributed to improved medical care and that "...alloca-

tion of more and more men and women, money, and machines has affected mortality rates only marginally." He continues,

I will not berate the medical profession, its practitioners and its professors - they reflect our culture, its values, beliefs, rites, and symbols. Central to the culture is faith in progress through science, technology and industrial growth; increasingly peripheral to it is the idea, vis-a-vis health, that over 99 percent of us are born healthy and made sick as a result⁵ of personal misbehavior and environmental conditions.

E. Patient/Learner Motivation

The motivation of the learner (patient) is clearly a pivotal factor if there is to be "education". For practical purposes, education can be defined as planned activities whose outcome is attitudinal or behavioral change. Human motivation is a complex of internal and external factors such as perception of personal control; attitudes toward (medical) authority; perception of threat (or importance); general social, religious, personal concerns and beliefs; demands of others; and more. Programs which do not assess and take into account individual motivation are more properly characterized as information rather than education programs.

The work of educator Malcolm Knowles is but one guide to understanding how people move toward insight and maturity. Knowles proposes that the goal of education is the emergence of maturity, and that the following dimensions should be considered as potential yardsticks. While it is dangerous to ascribe one column to children and the other to adults, the directions of growth can be described as concomitant with the passage from childhood into mature adulthood. (Note there are no absolute states).

While this course cannot address the issues and concerns of the adult learner in any detail, two references are suggested for those wishing more background information.

Knowles, Malcolm. Self-Directed Learning: a guide for learners and teachers. New York: Association Press, 1975.

Knowles, Malcolm. Modern Practice of Adult Education. New York: Association Press, 1970.

Chapter III explores the relationship of learner characteristics to program planning.

F. Exemplar Overview

An overview of existent programs, using type of site as a variable, begins to provide insight into the practical application of theoretical models, research outcomes, and common sense.

DIMENSIONS OF MATURATION*

FROM	TOWARD
1. Dependence.	Autonomy
2. Passivity	Activity
3. Subjectivity.	Objectivity
4. Ignorance	Enlightenment
5. Small abilities	Large abilities
6. Few responsibilities.	Many responsibilities
7. Narrow interests.	Broad interests
8. Selfishness	Altruism
9. Self-rejection.	Self-acceptance
10. Amorphous self-identity	Integrated self-identity
11. Focus on particulars.	Focus on principles
12. Superficial concerns.	Deep concerns
13. Imitation	Originality
14. Need for certainty.	Tolerance for ambiguity
15. Impulsiveness	Rationality

*Reproduced by permission of author from Malcolm Knowles, Modern Practice of Adult Education, (New York: Association Press, 1970), p. 25.

In large medical centers and systems, where resources can be expected to be greater and more varied, programs often evolve which produce their own teachers, materials and an on-going clientele.

Clinic settings, because of the way patients enter into the system, and because of the dispersal of resources are often characterized by more mobile, flexible programming which utilizes more community resources.

Community hospitals, small hospitals and clinics provide examples of imaginative blends of community resources and local staff expertise.

While proportions and interrelationships may vary, in all successful programs certain elements should be apparent as contributing to a fruitful outcome.

1. Administrative support and clear responsibilities.
2. Agreement on needs of the clientele.
3. Careful identification and application of resources.
4. Ample on-going publicity about program efforts.
5. Sufficient training and support of program personnel.
6. Sufficient evaluation to allow for developmental programming.

In the following sections of this course text these elements will be discussed and some strategies for successful implementation offered. In all, the role of the library should be addressed as it relates to the total setting, with the clear appreciation that individual strategies will vary widely.

NOTES

¹Victor Neufeld, "Patient Education: a Critique," in Compliance With Therapeutic Regimens, H. Sackett and B. Haynes (Baltimore: Johns Hopkins University Press, 1980).

²Robert D. Caplan et al., Adhering to Medical Regimens: Pilot Experiments in Patient Education and Social Support. (Ann Arbor: University of Michigan, 1976).

³Donald A. Bille, "The Role of Body Image in Patient Compliance and Education," Heart and Lung 6 (1977): 143-48.

⁴Washington, D.C., National Geographic Society, 1975. V/C - 28 min.

⁵John H. Knowles, "The Responsibility of the Individual," Daedalus (Winter 1977): 57-80.

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6. Kasl, S.V. "The Health Belief Model and Behavior Related to Chronic Illness." Health Education Monographs 2(1974): 433-54.
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CHAPTER II.

A. Role Definitions and Developments

For many health-care professionals Patient Education is an exciting challenge as well as a cause for concern and worry. Generally, where roles and interrelationships between services and professions are distinct and comfortable, the concerns diminish. The professional roles in patient education are being explored by the American Hospital Association as part of a grant project from the Bureau of Health Education, Center for Disease Control in Atlanta. Some valuable insights are surfacing.

From the outset, none of the groups surveyed (Dieticians, Nurses, Pharmacists, Physicians, Volunteers, Community Services personnel, Librarians, etc.) indicated that this was not in their area of concern. In fact, each group feels it has a significant role to play despite some areas of uncertainty. Unfortunately until individual professions and special emphasis groups feel sure of their own roles, they may appear unwilling to share the "turf" with others.

You may find it helpful to spend a few moments jotting down the roles currently played, or reserved, for each of these groups in your setting. Add any other significant groups and try to clarify their apparent role.

Current reserved role

Access to resources -

Access to decision makers -

Administration

Nursing

Medical staff

Dieticians

Pharmacists

Volunteers

Community services

Librarians

Therapists

Education specialists

Now do a second comparison for these same groups looking at such concerns as access to resources (dollars, space, people, etc.) and access to decision-making/policy-making bodies in your setting. Regardless of your perceptions of the need for patient education, and your felt role in it, this information is the "reality matrix" in which you must operate. Few of us are faced with a pristine, untainted situation into which we can freely move in self-defined roles.

As a practical matter, your perceived role will probably be limiting rather than broadening. One arena into which you can immediately step, and with very little difficulty, is that of a support service for those other professions with a more direct "hands on" relationship to patients.

It is axiomatic that people do not try to teach that which they do not know. Nor will most people attempt to "educate" if they do not feel competent and rewarded as teachers. If the library plays no other role in patient education than the support of staff who are directly involved, this is a most significant contribution.

Librarians have, in various settings, done such things as: amassed special patient education support collections for staff; amassed collections of exemplary (sample) teaching materials and catalogs; and provided linkage to local college, seminar, and community resources. Special situations may make it prudent to prepare a translator resource list; or identify second-language materials (i.e., Spanish, Vietnamese, Creole, etc.) resources; or provide a resource file for bulletin board and display materials. While none of these should be the limit of library involvement, each properly applied to the local situation can make a statement of supportive, knowledgeable involvement to other staff.

There being no prescribed role for the library and librarians can be either bane or blessing depending upon one's viewpoint. Experience would indicate that once the library joins the patient education team

effort, roles expand and diversify from setting to setting to a truly remarkable degree.

One role of the library which seems readily accepted vis-a-vis patient and family outreach is as a provider of information as to normal body structure and function. The American public, to the surprise of very few librarians, is remarkably unaware of basic human anatomy and function. Medical staff find this frustrating (when they acknowledge it) and generally seem quite grateful for materials which enhance this basic patient information level. A great range of materials exists to help provide this base-line information. Some include:

"The Human Body, A Machine At Work" Society for Visual Education (SVE, 1976. 8 slide/tape programs)

"Man: the Incredible Machine" (videocassette) National Geographic Society, 1975.

Hammond Human Anatomy Atlas. C.S. Hammond Company, 1960.

Until now, nothing has been said of the role of a particularly significant group -- the health care consumers. In fact it is they, perhaps more than any others, who are shaping and will refine the roles of all concerned professionals. Their demand for information of a general nature has altered the role of librarians in the public libraries, schools, and many special libraries, including medical libraries. The expectations of the consumer, and the unique pressures she/he can bring to bear will do much to identify priorities, modes of delivery and documentation of information, and address such significant concerns as funding resources.

B. Mandates, Benchmarks and Rationales

While there is no Constitutional or Bill of Rights mandate on health (no right-to-health law), there are legal statutes such as Medicare and Medicaid which create a government mechanism for funding health care delivery and certainly imply a "right to health and health care."

Occasional health care addresses by Presidents, documents such as the Forward Plan for Health, the 1974 National Health Planning and Resources Development Act, a large body of OSHA regulations, and other health related regulatory safeguards, create a sense that health, wellness and safety are perceived as rights of the citizenry.

Over 2,300 years ago Hippocrates wrote that "the physician must be ready not only to do his duty himself, but also to secure the cooperation of the patient, of those about him, and of his surroundings."

While it may seem that the primary impetus in patient health education has been provided by the fear of malpractice suits, it must also be acknowledged that patient education is simply a consumer concern whose time has come. The legal and institutional mandates are responses to the increasing awareness that the average patient knows little or nothing about becoming or staying well. (As an example, two polls

conducted by Louis Harris and Associates in the last few years indicated that a large proportion of Americans still cannot identify cancer early warning signs or symptoms of heart disease).

Frustration with the increasing health costs to consumers, employers, (and society in general) is being reflected in laws, insurance company policy statements, consumer-oriented pressure groups and professional standards.

At this point in time, attempting to identify all the mandates, standards, sanctions, statements, benchmarks, and rationales that accompany the patient health education movement is like trying to empty the ocean with a bucket. All you can do is try.

In 1973 the American Hospital Association approved the well-known "Patient Bill of Rights". Many hospitals have adapted this in their own policies. Several states have adopted or revised the Patient Bill of Rights into their own laws. Critical to this Bill of Rights is the concept that the patient has a right to choice-making information from the health care providers in language she/he can readily understand. The Patient Bill of Rights states that the "patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care."

In 1974, PL 93-641 the National Health Planning and Resources Development Act was passed. It was broadly concerned with such issues as service to under-served populations, uniform cost-accounting, the development of levels of care, and the promotion of activities for the prevention of disease. The Act also mandated the development of multi-institutional systems for coordination or consolidation of institutional health services.

In 1976, PL 94-317, the National Consumer Health Information and Health Promotion Act mandated a coordinated national effort to integrate health education research, community outreach, information programs, and the study of health education projects under an information clearinghouse system. Most importantly, the Act proposed the formulation of national health goals and strategies as well as a national assessment of resources. Support for training programs and the establishment of health education components throughout the spectrum of American life and education were also proposed. Funding remains an issue of great concern since the clearinghouse function alone is a massive undertaking.²

The Veterans Omnibus Health Care Act of 1976 stressed that patient health education must be extended to include the needs of the family. There was great emphasis placed on health education to reduce the incidence of chronic illness. This, coupled with various other V.A. statements and program initiatives, should make that massive health care system an excellent testing ground for programs and materials.

Mandates to specific departments and agencies of government are still evolving as the later discussion of national resources will indicate.

C. Informed Consent

The concept of informed consent has taken its place at the top of the list of mandates. While medical malpractice suits are relatively few and will probably continue to be so, one authority on medical law states that informed consent is the root and substance of malpractice.³ The inviolability of the person, that "no physician has the right to touch the body or psyche of a patient without the latter's expressed, implied, or reasonably assumed permission" is considered an ethical right.⁴

In September, 1981 the AHA House of Delegates approved its "Policy and Statement on the Hospital's Responsibility for Patient Education Services." The policy adopted states:

The hospital has a responsibility to provide patient education services as an integral part of high quality, cost-effective care. Patient education services should enable patients, and their families and friends, when appropriate, to make informed decisions about their health; to manage their illnesses; and to implement and follow-up care at home. Effective and efficient patient education services require planning and coordination and responsibility for such...should be assigned. The hospital also should provide the necessary staff and financial resources.

Physicians are beginning to acknowledge that their reliance on technical terminology often interferes with clear communication with patients. Clearly, no amount of time spent in "explanation" will guarantee "informed consent" if the words used have no common meaning between physician and patient. The solution seems to be to teach physicians to attentively communicate with, and elicit clear indications of consent from, patients.

The time involved, and the repetitive nature of such communication, has convinced many physicians that mediated patient instruction, followed by patient-physician conversation saves time and enhances learning.^{5,6} Identifying program materials acceptable to staff will be discussed later, but once physicians and nurses acknowledge that good materials can save time and reduce boring repetition for them, the effort becomes worthwhile.

From time to time rumors crop up that somewhere a well-intentioned librarian gave a patient health information and was later involved in a malpractice suit. Attorney Warren Eustis offers vigorous assurance that under the protection of the First Amendment such difficulties are extremely unlikely.⁷ The serious issue for most librarians has to do with their particular hospital's policy on the use of its medical library. Assuming patient use is tolerated, where the librarian has been able to build a collection with input from medical staff, the chance of being held liable for information is further reduced.

"Exceptional patients" such as children, non-English speaking persons, minors and psychiatric patients of course provide very special problems with regard to informed consent. The ethical guideline would suggest patient instruction with parent or guardian present and advising. Librarians involved in health education will find selecting materials in accordance with their assessment of the exceptional patient population especially challenging.⁸ In a hospital where such exceptional patients are found, the availability and documented use of specially adapted program materials becomes quite important.⁹

D. Current Awareness Resources

Keeping track of legal (and other developments) in health care is difficult. Some organizations such as SOPHE and APHA do fairly well. Newsletters such as Focal Points from the Bureau of Health Education and MLA News are helpful. State health agencies and chapters of SOPHE and APHA have varying degrees of success. The "Patient Rights Digest" from the Center for the Study of Civil Liberties and Civil Rights in Montgomery, Alabama was an outgrowth of a federal grant to produce a "Patients Rights Reporter" and may also be useful. Another resource, Health Law Vigil may be subscribed to from the American Hospital Association. This bi-weekly publication may be especially up-to-date on provider reimbursement. Finally, PROMoting HEALTH from the AHA is an excellent periodic resource.

One last final resource especially worth mentioning is the Consumer Health Information Newsletter published by the Consumer Health Information Committee of the Twin Cities Biomedical Consortium. This newsletter circulates to almost every state, several foreign countries and Canada, and serves as an information and resource conduit for librarians, health educators, physicians, university faculty in public health programs, and many more. It is an excellent example of librarians identifying an appropriate role and exercising the best professional skills and efforts to provide service.¹⁰

The consumer movement in health care will undoubtedly have substantial effect upon future planning and practice in health care. With the skyrocketing costs of medications, services, hospitalization, and insurance consumers will look increasingly for "do-it-yourself" remedies and strategies. Interestingly, the consumer effort has not been particularly well directed at health education, although some excellent programs have developed as a direct result of consumer pressure. One task force suggests that this lack of initiative relates to a general overemphasis of therapeutic medicine; a reluctance to accept personal responsibility for health; a fear that health educators might attempt shaping a new social order; and a non-responsive attitude on the part of health educators with regard to environmental and socioeconomic factors of health.¹¹

A brief, but excellent article by Dale Christensen and Albert Wertheimer indicates that there is high consumer interest in accountability but few mechanisms to encourage consumer participation.¹² The "traditional mechanism employed by consumers to evoke market responsiveness - the refusal to purchase - has been largely ineffective

in influencing health care delivery".¹³ There are indications that consumers will pay directly for mediated health education if it is clearly explained that this will help them achieve an improved state of health. (Convincing third-party payers to cover the costs remains a thorny problem for many health educators).

Groups which are able to influence, finance, and guide consumer interests in health care include: health insurance carriers, labor unions, HMO's, professional and community organizations, industries, public health departments and many more. As shall be discussed later, these groups can also become valuable resources in the conduct of a program.

In September, 1971 the President's Committee on Health Education was formed. During the next two years experts in the field of health education met as subcommittees, held eight regional meetings and a national forum. Their major recommendation was twofold: that a focal point be created within federal government, the Bureau of Health Education; and that a complimentary national focal point be created. The latter became the private, non-profit organization called the National Center for Health Education.¹⁴

The Bureau of Health Education was established as part of the Center for Disease Control in September, 1974. Its mission is to provide leadership and direction to a comprehensive national health education program. The Bureau through its ability to grant contracts (for example, the AHA surveys) is able to provide research and information.

The National Center for Health Education became operational late in 1975, and has been funded by a variety of private sector foundations, companies, and other interested parties. The National Center has five major roles in health education. They are to provide leadership strategy, to act as an advocate, to act as an information exchange, to provide technical assistance, and to help conduct evaluation. Ideally, the National Center and Bureau for Health Education prod each other, cooperate with each other and help the evolution of a truly national effort.

So far, librarians have not been much in evidence at national or regional meetings in which these national policy-defining organizations participate. This overview of mandates should make one thing very clear -- there is a fragmentation in health education that becomes increasingly intolerable as pressure for action rises.

Librarians must reexamine their role as information managers and be part of the formulation of solutions if they are to really be considered part of the health care team. Finally, librarians will need to work in concert with the other professionals involved with health education if they wish to take on an active role in this complex enterprise.

In a given situation the most important mandates are those developed locally. All of the legal and ethical concerns must be translated

codified into local understandings or policy statements. These policy statements must identify the hospital's scope of responsibility.

The patient health education process requires the participation and support of three distinct groups: the patients; the staff concerned with program development and conduct; and the administration concerned with evaluating and supporting that program. It is vital that the responsibilities of these three groups be clearly defined with regard to their accountability at the patient care, program development, and systemic support levels. The early declaration of local policy and responsibility can prevent a great deal of later wheel-spinning. The hospital librarian who feels obliged to become involved in patient health education is advised to become involved at the policy defining stage.

NOTES

- ¹"Statements about the health education roles and responsibilities of selected health care providers". Contract #200-79-0916 Center for Health Promotion, A.H.A. and Center for Health Promotion and Education (CDC) Atlanta, Georgia 30331. Sept. 1981.
- ²National Health Information Clearinghouse, P.O. Box 1133, Washington, D.C. 20013. Phone 800-336-4797.
- ³Warren Eustis, Tenth CCH Health Educator's Workshop. January 11-13, 1978, University of Minnesota, Minneapolis, Minnesota.
- ⁴John F. Monagle, "Ethical-Legal Considerations of Informed Consent," Hospital Progress (September, 1974): 58-61.
- ⁵Penn Skellern, "A Planned System of Patient Education," JAMA 238 (1977): 878-9.
- ⁶Mitchell Rabkin, "The Needs of Patients," New England Journal of Medicine 288(1973): 1019.
- ⁷Warren Eustis, Private Communication.
- ⁸"Library Service to the Disabled: An Annotated Bibliography of Journals and Newsletters," The Serials Librarian 5(1980): 49-60.
- ⁹The identification of such materials will be discussed further in this syllabus, but one special resource is worth noting, Directory of National Information Sources on Handicapping Conditions and Related Services. Human Development Services, HEW. Publ. (OHDS) 80-22007 May, 1980.
- ¹⁰This free bi-monthly is available by contacting the editor, Eleanor Otterness at Group Health Plan, Inc., Rm. 608, 2829 University Ave. S.E., Minneapolis, MN 55414. Subscribers are encouraged to freely copy and distribute the Newsletter and to contribute any items of interest.

- ¹¹Sponsored by John E. Fogarty International Center for Advanced Study in Health Sciences, NIH, and American College of Preventative Medicine, Preventative Medicine USA (New York: Prodist, 1976).
- ¹²"Consumer Action in Health Care," Public Health Reports 91: 406-411.
- ¹³Ibid, p. 140.
- ¹⁴211 Sutter St., San Francisco, Calif. 94108.
- ¹⁵Federal Register, 39:186 p. 34315.

CHAPTER II - READINGS

1. American Hospital Association. Roles of Professionals in Health Education. A.H.A./B.H.E. Health Education Project. Contract #200-79-0916. (840 N. Lake Shore Drive, Chicago, Ill. 60611)
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3. American Hospital Association. Health Law Vigil. (bi-weekly subscription)
4. American Medical Association. Statement on Patient Education. Adopted by the AMA House of Delegates, June 1975. (535 N. Dearborn St., Chicago, Ill. 60610)
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CHAPTER III.

A. Characteristics of Learners

One prescription for effective patient education states:

Patient education should consist of organized health educational experiences, planned by physicians, professional health care workers, and the patient himself to meet the patient's specific learning needs, interests, and capabilities, and offered¹ as an integral part of the patient's total health care.

In an age where media is regarded as educational, where information and education are widely confused terms, and where mass "education" is the mode, this emphasis on the patient and his/her peculiar needs is problematic. Few health care workers (or librarians) are skilled educators able to discern the needs of the individual and weigh them against available teaching and delivery styles. Nonetheless, there is much to support the contention that this is precisely what we must do.

As the mandates and benchmarks of patient health education have evolved, more and more consideration has been given to acknowledging the unique needs of each patient. Whether or not librarians actually conduct patient education, they are part of the education continuum and must therefore understand the learning styles of their potential patrons if they are to serve them wisely.

Too often along the education continuum we treat all learners as a common group. Learners are, in fact, unique individuals who are often grouped (in the name of economy) with others who may or may not bear resemblance to them. "When the approach to patient education is focused on the learner rather than on the content or instructor, the health worker² must accept the premise that the patient is the decision maker."

Implied in the acceptance of the patient as decision maker is flexibility with regard to materials, teaching sites, order of instruction, and even instructor. Depending upon the age, abilities, and disposition of the patient these are important variables. One of the strongest and most successful arguments on behalf of library involvement in patient health education is that it can add a significant dimension of manageable flexibility to hospital based programs.

Where pre-selected materials (print or media) are appropriate, they can be made available in a variety of settings, at almost any time, and as often as desired by the patient or the interested family. Few physicians can afford to be that flexible. The crucial staff consideration then, is not where, when or how a patient is given instruction, but how teaching is integrated into the patient's care program. By sharing a common body of information with a patient, and then spending time helping the patient (or patient and family) draw conclusions and

plans of action pertinent to him/her, the staff makes informed compliance much more likely.

What then, are some generalizations that can be made about types of learners? What are some guidelines for the caring staff and librarian who wish to identify resource materials for patient instruction?

First, no single theory can be readily used to explain how people learn. Stop for a moment and jot down the factors you think would affect whether or not you will learn a new "healthier" way to cook. Assume you are hospitalized for stomach cramps and have been told you have a class to attend in half an hour.

Factors that would incline me to learn:

Factors that might interfere with learning:

Having done that exercise, ask yourself if you are someone who believes that events impacting upon your health are controlled by you directly, or that they are combinations of luck, the influence of others, fate, and so forth. Having done a very quick, superficial self-assessment, it may now be useful to look at some basic findings about adults and learning.

Marshall Becker in his Health Belief Model directs attention to several components presumed necessary to assure patient compliance. The literature of compliance studies, cited in the first chapter, is replete with studies specific to given components, diseases and interventions.

Of great importance to compliance (learning to do what is prescribed) is the perception of threat or risk -- susceptibility. This is dependent upon the patient's perception of the accuracy of the diagnosis, the likelihood that this illness can, will, or has recurred, and the patient's general feeling of vulnerability to illness. Librarians who deal with the lay public can readily cite examples of reference questions couched in second-person terms to disguise fears of susceptibility.

A second impactor on learning is the patient's subjective understanding of the severity of the illness. Although this is not clearly predictive of compliance in preventive teaching situations, it does seem that where illness is present (or another attack seems imminent) patient perception of severity is predictive of behavior changes (learning). In many hospitals nurses intuitively place patients with initial onset of diabetes and heart disease with patients whose lack of self-care has led to disease exacerbation. This can be an effective enhancer or motivator to patient education.

We are also moved to learn, or not learn, new behaviors based on our understanding of cost-benefit relationships. This, however, is powerfully mitigated by factors other than our desire for benefit. While an elderly person on fixed income may desire hypertension control, the dollar costs of a low sodium diet may be such that compliance seems impossible. Or, the "patient" may not be the cook. This may explain, among other reasons, the numerous reference questions regarding those alternative therapies which seem less rigorous (costly) than the standard medical regimens. In a library collection serving the lay public this concern with comparing therapies for cost-benefit requires either a broad collection or a clear, written policy to supply information only on therapies provided or supported in the hospital. While the latter may be philosophically repugnant as a type of censorship, it may also be tempered (in the hospital setting) by a policy of directing patrons to other resources such as the public library.

Whether people learn (and therefore change behaviors) or not is also a function of whether they see themselves as being in control of their health. In its simplest sense, this means that someone whose life experience has been such that positive reinforcement (good outcomes) is associated with certain behaviors, will be likely to repeat those behaviors. If, for example, you faithfully brush your teeth twice a day, see a dentist yearly, floss daily, and have no cavities, you are probably going to comply with a new therapy to prevent gum disease. If, on the other hand, you do not associate lack of careful oral hygiene with your high level of tooth decay, you probably will not comply with any new regimen.

Other factors such as available social support systems (co-learners), prevailing local mores, level of education, age, and relationships to health care practitioners take on great importance in learning. As a consequence, few generalizations can be made about patient teaching and few (if any) "pat" programs can be devised to meet all the educational needs of a particular group of patients. Again, it is in this need for flexibility that the potential for library involvement and the use of various media seems greatest.

There are some general principles of adult learning which can be helpful in formulating educational programs. These can be merged quite compatibly with the precepts of the Health Belief Model.

One definition of patient education states that it is a "process of growth" and indeed some methods of evaluation attempt to gauge the patient's progress along one or several maturational paths. The concepts of pedagogy and andragogy advanced by Malcolm Knowles can help provide a framework for assessing the acceptability of patient education programs.

B. Pedagogy Versus Andragogy

Pedagogy, derived from the Greek stem Paid ("child") and agogos ("leading") is the art/science of teaching children. Such phrases as the "pedagogy of adult education" are contradictory in terms, but

A COMPARISON OF ASSUMPTIONS AND PROCESSES OF
TEACHER-DIRECTED (PEDAGOGICAL) LEARNING AND
SELF-DIRECTED (ANDRAGOGICAL) LEARNING*

(Please read as poles on a spectrum,
not as black-and-white differences)

ASSUMPTIONS

<u>About</u>	<u>Teacher-directed learning</u>	<u>Self-directed learning</u>
Concept of the learner	Dependent personality	Increasingly self-directed organism
Role of learner's experience	To be built on more than used	A rich resource for learning
Readiness to learn	Varies with levels of maturation	Develops from life tasks and problems
Orientation to learning	Subject centered	Task or problem centered
Motivation	External rewards and punishments	Internal incentives, curiosity
<u>Elements</u>	<u>Teacher-directed learning</u>	<u>Self-directed learning</u>
Climate	Formal authority-oriented, competitive, judgmental	Informal, mutually respectful, consensual, collaborative, supportive
Planning	Primarily by teacher	By participative decision-making
Diagnosis of needs	Primarily by teacher	By mutual assessment
Setting goals	Primarily by teacher	By mutual negotiation
Designing a learning	Content units, Course syllabus, Logical sequence	Learning projects, Learning contracts, Sequenced in terms of readiness
Learning activities	Transmittal techniques, Assigned readings	Inquiry projects Independent study Experiential techniques
Evaluation	Primarily by teacher	By mutual assessment of self-collected evidence

*Reproduced by permission of author from Malcolm S. Knowles, Self-Directed Learning, (New York: Association Press, 1975), p. 60.

true in practice. Knowles' statement that "...most teachers of adults have only known how to teach adults as if they were children" seems terribly true.³

Pedagogy is characterized by several assumptions which are tolerable only in the strictest context of compulsory schooling of children. Pedagogy assumes that the purpose of education is to transmit knowledge. Certainly in the health care setting there is ample evidence that knowledge alone does not lead to behavioral change (compliance). That is, smokers smoke despite grim warnings and statistics; hypertensives continue to use salt and be overweight despite proof that blood pressure is adversely affected; and people continue to ride without seat belts in cars. Since the goal of patient health education is to allow the individual to interpret and integrate behavior in such a manner as to bring about attitudinal and therefore behavioral change, the mere transmittal of information cannot suffice.

Andragogy assumes that the learner is not completely dependent upon others for all but the simplest biological needs. The adult learners see themselves as doers, producers. They consider themselves self-directed, and need to have their self-direction recognized. One of the critical concerns in designing adult education should be to elicit from the learners what behaviors, settings, and materials they consider inappropriate -- and will therefore resist. The librarian who bears this in mind as materials (print and audiovisual) are previewed will soon discover that much of what is commercially available in health education is disastrously mis-labeled as being at the "adult level".

Despite the adult learner's desires to be self-determined and self-directed it seems a sad fact that most adults are not prepared to be self-directed learners, often they must go through a re-education (un-education, if you will) process.⁴

Of course, patient education efforts must be directed toward children and adolescents as well as adults. While the desired end result, knowledgeable participation in one's health care, may be the same, educational means will differ somewhat.

Librarians wishing to implement pediatric health education programs may have a variety of material and planning resources available through local schools, child development councils of health departments, various federal agencies which offer everything from nutrition board games to series of pamphlets for new mothers.

Children today are more accustomed to audiovisual presentations in education and so may be much less resistant to such teaching situations as closed circuit television and movies. Reliance on these media may present problems because of the need to divide health care decision-making responsibility realistically between parent and child. Closed circuit television also presents some documentation problems which will be discussed later.

Since it is unlikely that children would be allowed in the medical library, alternatives such as mobile display and materials carts or pediatric ward mini-libraries can be explored where they do not already exist. Children learn by handling, doing, and sharing, so materials such as unbreakable models, laminated charts and blackboards with teaching templates are most appropriate. Cassette tapes will survive better than records, videocassettes will outlast films and pictures and posters will be easier to handle than slide trays.

Young adults may find mixed group health education embarrassing. Their body changes and changing relationships with the opposite sex often interfere with comfortable learning. Happily, there are more and more books of high caliber available on a wide range of health topics for young people. Consultation with a school or public librarian, publications of The Association of Specialized and Cooperative Library Agencies of ALA (ASCLA), "Kids and Self-Care" can all be useful. Since youth need an individualized mix of pedagogy and andragogy, the best advice for librarians concerned with youth health education is plan for flexibility. While it may be inadvisable to invite youths into the medical library, a young people's collection on a booktruck may enable ward staff to bring appropriate materials to their patients. Some hospitals have formed advisory linkages with school and public librarians to facilitate either identification and review of materials, or access to non-hospital collections.

C. Physical Considerations of Learners

Humans, as they age, have changing needs which are particularly relevant in planning a physical facility for their health education. Vision peaks in the early 20s, from then on we need additional time to refocus eyes and additional lighting (between 20-25 feet, candle power.) Printed materials should have 10 point type, 10-12 words per line. Newspaper columns with 5-7 words per line are easiest to read. Extra large type can be as hard to read as too small type.

Room colors for classrooms can be quite important. In order of preference (both sexes) colors are: green, blue, red, yellow, orange, violet, white. Blackboards are easiest to read if green with yellow chalk, or gray with white chalk. They must be away from windows to prevent glare or shadows.

Hearing peaks at about age 14, and most adults develop adaptive behaviors which cover hearing loss. Care must be taken that all participants can see each other in group settings. Films shown on equipment with distracting mechanical hums are frustrating and taxing. (Videocassette, CCTV, behind-the-screen projectors are most satisfactory).

Finally, room temperature (69° - 73° in summer, 66° - 70° in winter), furniture selection and placement must take adult needs into account. Obviously, the bean-bag chairs that children and youth might enjoy are inappropriate as are many other non-supportive or low chair styles. Tables should be high enough for wheelchairs, carpets dense enough for wheelchairs and walkers to move easily, and small pieces

and accessories such as floor-model ashtrays kept to a minimum. Actual space per patient may be difficult to determine, but bear in mind the space and architectural needs of wheelchairs. Remember, too, that often the patient and a family member will want to view materials together -- and with a modicum of privacy. One possible, reasonable number may be 30 square feet per patient.

The question of allowing adult patients physical access to the medical library is a difficult one for many institutions. Donald A. Billie argues in favor of such privilege:

In addition, adults have acquired a number of fixed habits, and therefore they may be less open-minded about changing. One of the habits adults may have developed is looking to books for answers to problems they have identified. ...If he (the patient) recognizes a need to learn, and asks a librarian to help him meet that need, he must be helped at that time -- the teachable moment -- otherwise, the need will dissipate, and not come back, and the adult will have learned that he cannot come to the library to find out information when he needs it. ...It should be pointed out, in conclusion, that the hospital based librarian can have a positive impact on patient education, and that patients will react favorably...

Billie is very clear on the responsibility of the librarian to communicate the nature of the inquiry and materials given to ward staff. Obviously this provides more continuity of information for patients; a ready mechanism for clarifying and documenting patient questions; and very importantly, a realization on the part of ward staff that the library is an available, trustworthy resource.

This by no means represents a complete guide to individualizing patient health education. What must be made clear is that unique learner needs exist, must be identified, and met wherever possible. The librarian in a health care setting will need to work with others in the hospital or clinic to assess what "types" of learners are to be offered service and what materials, staff resources, and agency resources exist. No single physician, nurse, educator, health planner, or librarian can hope to be proficient in meeting the health education needs of any but the most limited population. But, where all work as a health care team the library can become a:

vital center serving the hospital's objectives of patient care, education and research. ...It's true value lies in its ability to identify and provide information to all who need it. ...It represents all the interests of the hospital. ...To the extent that the health science library is successful in fulfilling its mission, the hospital will be successful in providing effective educational and research programs at all levels and in fulfilling its goal of better patient care.

NOTES

- ¹K.M. Kelley, M. Ulrich, "Patient Care Includes Teaching," Hospitals 46(1972): 59-65.
- ²Jeannette Simmons, "An Overview of Patient Education," Patient Education Workshop, Summary Report, Bureau of Health Education, Center for Disease Control, January 26-27, 1976, p. 25.
- ³Malcolm Knowles, Modern Practice of Adult Education, (New York: Association Press, 1970), p. 37.
- ⁴Malcolm Knowles, Self-Directed Learning: A Guide for Learners and Teachers, (New York: Association Press, 1975).
- ⁵Special issue of Medical Self Care, Spring, 1977.
- ⁶Donald A. Billie, "Panel Discussion on Patient Teaching" meeting of Hospital and Nursing School Librarians of the Midwest, October 29, 1976.
- ⁷AHA, 1969.

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CHAPTER IV.

A. Program Examples

A prevailing lament in health education deals with the fragmentation of information and dissemination of evaluation efforts. This is keenly felt when trying to identify program exemplars and resources. A significant, related issue is that in the federal sector at least, there are counterproductive and inconsistent policies which tend to hinder the evolution of exemplars. An excellent discussion of this aspect, and the need for more decisive national leadership can be found in Health Promotion and Consumer Health Education.¹

Because of the high initial costs and commitment of staff time required to institute a patient health education program, it is vital that all available resources be identified and utilized.

Two national information and coordination resources have been mentioned in earlier chapters, the National Center for Health Education and the Bureau of Health Education. Particularly in the federal sector there exists a wide range of health information interests in need of coordinated reporting. The many federal agencies involved in patient or consumer health education are, to varying degrees, providing resources, information and guidance. Among these are:

- National Clearinghouse for Alcohol Information
- Health Service (Dept. H.E.W.) Drug Abuse Information
- National High Blood Pressure Information Center
- Food and Drug Administration
- Center for Disease Control
- Office of Consumer Affairs (H.E.W.)
- National Heart, Lung and Blood Institute
- National Institutes of Health
- Public Health Service Regional Offices
- National Cancer Clearinghouse
- Veterans Administration

The Federal Trade Commission and Federal Communications Commission both have obvious interests in truth in advertising of health care products.

Similarly, there are abundant state, county and city programs. States have health planning advisory groups; cities or metropolitan areas have health boards which plan, fund, and direct a variety of health related programs. County extension services often have nutritionists and others who can provide consultation.

A directory of Area Health Education Centers (Federal, State, Local, Private) is available from the Bureau of Health Manpower, Department of Commerce. This identifies staff education projects as well as patient and consumer education initiatives.

National Foundations interested in health education abound. Many will provide materials, films, and consultation at little or no

cost.² Some which should be widely useful are:

- American Cancer Society
- American Dental Association (be sure to get their catalog)
- American Diabetes Association
- American Heart Association (they charge for pamphlets, try to get their main catalog for pricing information -- it saves time)
- American Lung Association
- Epilepsy Foundation of America
- National Council on the Aging
- National Coordinating Council on Drug Education
- National Easter Seal Society
- National Foundation for the Blind
- National Foundation March of Dimes
- National Hemophilia Foundation
- National Kidney Foundation
- Parkinsons Disease Foundation
- United Cerebral Palsy Association
- Zero Population Growth

Service and special interest groups such as 4-H, American Red Cross, the Dairy Council, National Retired Teachers Association can also provide special resources.

Community organizations such as churches, Rotary, Lions Clubs and Jaycees may offer space, funds or volunteers. They may be able to donate audiovisual equipment. Hospital auxiliaries may provide both funding and human resources.

Local colleges and universities may provide help in planning and evaluation. Students may be able to develop media and supporting materials, faculty may be able to provide staff training.

Self-help or mutual aid groups such as Alcoholics Anonymous, Gamblers Anonymous, Overeaters Anonymous, Women's Collectives, Ostomy Clubs, Reach for Recovery groups, and therapeutic communities often produce materials for free distribution or sale, and generally have much to offer as consultants and educators.

In 1975 an AHA survey indicated that about 33 percent of the respondents used outside consultants for patient education activities. Smaller hospitals (i.e. bedsize of 6-199) were the predominant users. Of the outside consultants, 41.8 percent were voluntary agencies. The remainder, in order of cited frequency were: private sector agencies, persons/specialists, hospitals/medical centers, schools, government agencies, and commercial companies. Community support groups were identified as teachers in 42.9 percent of responses.

While professional societies such as the AHA, various medical and nursing groups, often seem more interested describing policy than producing materials, they too can offer useful guidance. The AHA catalog is well worth perusal. Some of their programs and aids worth considering are:

- "Health Education: role and responsibility of health care institutions". Statement, 1975, AHA 5010
- "Professional Accreditation, and Legal Statement Supporting Patient Education". 1977. Booklet - Catalog #PO15.
- "Selecting Media for Patient Education: Book and Videocassette". 1978.
- "Medication Teaching Manual: A Guide for Patient Counseling". 1980, AHA 160172
- "Implementing Patient Education in the Hospital". 1979. (book) AHA #070188
- "Staff Manual for Teaching Patients About Rheumatoid Arthritis". 1979, AHA 070112
- "Staff Manual for Teaching Patients About Diabetes Mellitus". 1979, AHA 070118
- "Staff Manual for Teaching Patients About Hypertension". 1979, AHA 070119
- "Staff Manual for Teaching Patients About Chronic Obstructive Pulmonary Diseases". 1979, AHA 070117

Professional organizations offering support to health educators include:

- American Society of Health Manpower Education and Training (ASHET)
- Society of Professional Health Educators (SOPHE) (publishes quarterly Health Education Monographs)
- Association for Hospital Medical Education (AHME)
- American Public Health Association (publishes The Nation's Health, the American Journal of Public Health and special conference and symposia proceedings.

Others specifically concerned with school health are:

- American Association of Advancement of Health Education (affiliated with National Education Association)
- American School Health Association
- American College Health Association

Finally, an organization with many health science interests which brings together librarians, educators, and medical media producers is the Health Sciences Communications Association (HeSCA). One activity of the Biomedical Libraries Section, has been to meet with producers of health education software and discuss areas of software management concern. Other concerns are furthering cooperative activities with NLM, providing catalog access to new audiovisual productions in all health science fields, and providing workshops at annual meetings. HeSCA publishes a newsletter (Feedback) and the Journal of Bio-Communication (with the Association of Medical Illustrators).

Third party payers (insurance companies), HMO's and some occupational health programs can also provide resource materials and program data. The much cited Blue Cross Association White Paper, approved by the Board of Governors in August, 1974 stated:

It is appropriate that the Blue Cross system encourage the development of cost-effective programs in patient education. Where patient education is properly related to the other components of the total patient care process, there is clear potential for reduction of health care costs and improvement in the quality of health care processes and outcomes. Blue Cross Plans share responsibility with those providing patient education to ensure that this potential is realized. Accordingly, the Blue Cross System should play an active part in the development, implementation, and evaluation of sound programs in patient education.

As shall be discussed in a later chapter the fine rhetoric of the White Paper has not yet been translated into consistent payment for health education. Nonetheless, this is one area where consumer pressure may be brought to bear. There are indications that labor union concern with employee health and well-being may bring pressure to routinely cover such health education programs as those for lower back pain, heart disease, and chronic obstructive pulmonary disease.

Health Maintenance Organizations have been very active in seeking out ways to reduce health care costs and inappropriate use of the health care system by instituting planned patient education activities. Most often this is occurring in a clinic setting, although much of what is being learned can be valuable in designing inpatient education programs.

Much of the HMO activity in patient health education is designed to satisfy a 1973 requirement that to be eligible for federal financial support an HMO must provide "education in the contribution each member can make to the maintenance of his own health."^{4,5}

Finally, in the area of occupational health there are programs particularly geared to health screening which are being developed at the work site. One very extensive program implemented by the Kimberly-Clark Company in Neenah, Wisconsin emphasizes screening employees, providing education programs for employee and family, and documenting the cost benefits of such an employer sponsored program.

It is always helpful to find program exemplars from which to learn and borrow expertise. What follows is a subjective list of some of the oldest, most innovative, or most practical programs. Bear in mind that all are clearly consumer health information programs, but not all are patient education programs.

1. The Kaiser-Permanente Medical Center in Oakland, California has been cited since 1969⁶ for its focus on preventative medicine and health education.

The Patient Health Library emphasizes the use of audiovisual materials (on referral or walk-in basis) in a setting that clearly defines the library as part of a total educational resource. Print materials are available and an extensive

pamphlet collection provides additional service. A similar program at the Cleveland Health Museum and Education Center provides materials for reference use only.

2. In the greater Boston area, the Community Health Information Network (CHIN) links public libraries of several cities with the Health Sciences Library at Mt. Auburn Hospital, Cambridge, Massachusetts. This service was established using Title III funds of LSCA and NLM grant. This program bridges a gap between inaccessible medical libraries and insufficient public library collections to provide telephone access to health information for consumers, public libraries and health providers.
3. In another example of cooperative resource sharing the Los Angeles County Public Library System and Los Angeles County Department of Health Services received Title I (LSCA) funding for a bilingual Consumer Health Information Program and Services (CHIPS). Using the Tel-Med system, a Health Information Line provides single topic audiotapes in English or Spanish on a variety of health care topics.

Both cooperative systems provide meaningful alternatives in areas where funding or other limitations preclude immediate development of a broad range hospital or clinic health education program, although neither takes the place of a hospital-based patient education program. Both provide data for regional needs and resources assessment, staff development opportunities and greater access to health information for the public.

4. In some hospital settings patient health education outreach is severely limited by space, budget, and staff. The Paoli Memorial Hospital provides an example of a simple, effective book-cart project which brings medical information to the layperson despite the lack of a formal patients' library.
5. In the Veteran's Administration Medical Centers, where patient libraries have long existed as a resource, several new directions are being tried. Several V.A. hospitals have formally designated patient education support services in the library. A variety of models, books, pamphlets, and audiovisual programs on health topics are made available to patient and family in the centers or at bedside, on referral, or by walk-in request. All are staffed by professional librarians and rely heavily on a health care team approach to patient health education. In the network of V.A. hospital libraries other program strategies and initiatives defined by the unique needs and resources of each hospital are evolving.
6. The American Hospital Association is compiling a dossier of library programs in patient education as a result of a large study grant. This should be completed and available in Autumn, 1982.

B. Varied Librarian Roles

Programs are evolving which are creating new roles for hospital librarians vis-a-vis the professional staff. Clinical librarians, who make rounds with physicians and attempt to identify and meet information needs on-site are in unique positions to develop parallel programs for staff and patients. LATCH (Literature Attached to Chart) projects are traditionally used as information/education devices for medical staff, but can easily be adapted and expanded to embrace patient outreach. Both of these types of outreach promote much closer working relationships with medical staff. Both also place new demands on library staff time. Librarians examining the value of such time expenditures may find a recent article on the value of case related literature of interest.⁹

Librarians are involved in any number of interrelated roles. This brief summary list, while not all inclusive, indicates the range of activity possible.

Librarian/Patient Education Coordinator - in practice at the Minneapolis V.A. Medical Center. Librarian is the hospital conduit for acquisition, development, and dissemination of patient education materials.

Librarian/Resource Center Coordinator - Kaiser-Permanente, several VAs and various hospital settings. Here the library may be less involved in production and development of materials, but acts as central circulation control and a delivery facility.

Librarian/Patient Education Committee Representative. This vital role recognizes the value of professional librarians as resource identifiers and as organizing agents.

Librarian/Department consultant - In this role a librarian functioning as a clinical librarian may work with a specific department (pediatrics, ob-gyn) to develop teaching resources for patients. In another mode, the librarian may work as an advisor to nursing education (frequently the coordinating service for patient education).

Librarian/Resource person - Generally this role requires a great deal of initial public relations work aimed at convincing patrons that they should expand beyond traditional concepts of the library. In very large medical centers and university settings, medical librarians may serve primarily as resources to the professional staff. Here, the assembly of a professional resource collection may be sufficient contribution from an already taxed staff.

C. Wellness and Self-care Programs

Two complementary new directions in medical care are noteworthy because of the special tools and programs being developed around them.

These are the wellness and self-care practices. Both have their genesis in grass-roots consumer movements, and both reflect the cyclic nature of health care, in that each represents a "back to the basics" approach.

Self-care is essentially shifting the emphasis from expensive medical interventions to knowledgeable self-assessment and treatment.¹⁰ Self-care practitioners may encourage home specimen gathering for strep culture, home use of various "doctors bags"; and the use of non-traditional, trained caregivers who operate at the neighborhood level. These programs have evolved their own literature, spearheaded by "How to be..." "How to do..." titles which are increasingly popular. One excellent, thorough tool used by self-care practitioners, as well as librarians serving the lay public, is the journal Medical Self-Care.¹¹ Its reviews of books, current health topics and single topic issues make it an excellent ongoing research.

Wellness practices are neither new or revolutionary -- they are in fact quite similar to medical practices of the Orient. They emphasize personal responsibility for health maintenance and rely heavily on the motivation of the client. The emphasis on optimal vigor (wellness) encompasses such areas as health and exercise, diet and stress-reduction. Here again, consumer education is a primary component.

Self-help groups have characteristics of both self-care and wellness programs, and present unique resources to health educators. Lowell Levin presents an overview of those programs and some of the resources they represent.¹² Access to these groups by health education planners can often save program planning time and effort because of the high level of specialization and consumer input these groups represent.

Certainly health education planners need to be familiar with ongoing programs relevant to their special interests and needs. Again, the medical librarian can serve as an essential information conduit for staff by becoming sensitive to local health education concerns as well as industry-wide developments. Knowledgeable support of staff information needs can form the basis for later involvement on a broader scale.

NOTES

- ¹Preventative Medicine, USA, (New York: Prodest, 1976).
- ²A nice little guide entitled "Health Education Materials and the Organizations Which Offer Them" is available for a nominal charge from the Health Insurance Institute, 1850 K St. N.W., Washington, D.C. 20006.
- ³For on-going reports: the Self Help Reporter, c/o National Self-Help Clearinghouse, Graduate School and University Center/CUNY, 33 W. 42nd St., Rm. 1206A, New York, NY 10036. \$10/yr., 1981.
- ⁴PL 93-222 sect. 1301 (c) (9).
- ⁵S. Deeds and P. Mullen, "Managing Health Education in HMO's Pt. 1;" Health Education Quarterly 8, Winter, 1981. Whole issue. Pt. II should appear Spring, 1982.
- ⁶F. Bobbie Collen, "A Health Education Library for Patients," Health Services Reports, 89(May - June, 1974): 236.
- ⁷For information: CHIN Office, Mt. Auburn Hospital, 330 Mt. Auburn St., Cambridge, Mass. 02138.
- ⁸Medical Library Association, MLA News, (June 1977): 5.
- ⁹Georgia Scura, "Case Related Use of the Medical Literature," JAMA 245 (1981): 50-52.
- ¹⁰Donald W. Kemper, "Medical Self-care: A Stop on the Road to High Level Wellness," Health Values: Achieving High Level Wellness 4(1980): 63-68.
- ¹¹Medical Self Care: Access to Health Tools, P.O. Box 717, Inverness, California 94937.
- ¹²Lowell Levin, et al., Self-Care: Lay Initiatives in Health, 2nd ed. (New York: N. Watson, 1980).

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5. Rees, Alan. Consumer Health Information Source Book. (New York: Bowker, 1981).
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CHAPTER V.

A. Planning Models

Patient education planning models can take a variety of fancy forms which may or may not enhance the process. In its simplest form, the following planning model is applicable for any educational process. Rather than try to address what a hospital/clinic must do to plan a health education program, this chapter will deal primarily with the systematic process a librarian must apply to determine what services can realistically be offered.

The five stages are:

1. Assessment of the educational needs of patient, family and staff.
2. Goal setting as to the services to be offered.
3. Selection of appropriate methods, materials, and teachers to meet those goals.
4. Delivery of program.
5. Evaluation of the whole effort.

B. Needs Assessment

As has been discussed earlier, learning is not simply the acquisition of information, it includes acquiring and retooling skills or attitudes. It is vital to remember that in every patient education situation there are three distinct sets of needs which must be assessed -- those of the patient, the family, and the staff. (Sometimes, the needs of administration add a fourth dimension.)

Patient needs can be identified in myriad ways:

1. The patient whose disease is out of control is sending obvious signals.
2. The patient who seeks out information givers (or sends an emissary) is clearly signaling need.
3. The patient who repeatedly returns for inappropriate visits to the hospital or clinic is often demonstrating a need for education.

A number of devices are available to librarians who wish to help identify patient information needs. They take varying amounts of time and staff effort and should be selected in cooperation with other concerned health professionals.

All methods for collecting assessment information should be objective and replicable. All the interested parties (patients, family,

and staff) must be identified in order to assure that a full range of needs are assessed.

It is useful to know the ten major admitting diagnoses and ten major surgeries performed at a given setting. (Ten is suggested only because it seems manageable and should pick up the major concerns). Medical records services should have that information readily available. Looking at several years figures may help discern significant trends. Knowing these ten diseases and surgeries should enable the librarian to identify which staff people must be contacted as resources. It also provides a beginning acquisition (or non-acquisition) strategy.

A similar compilation of clinic visit data may well indicate a different ordering of major diagnoses, but generally will reflect parallel concerns. Since the materials used and delivery system may be quite different for hospital and clinic it is important not to generalize in assessing one with the other.

Where possible, tallies or files of reference questions can be kept. This can be done by library staff if patients attempt to find information there, by volunteers or personnel working at hospitality/information desk, or on the wards. (Single key-word tallies should suffice). A tally should only be attempted if there are indications of patient activity in this area since it requires much time and is only partially reflective of needs.

With cooperation, it may be possible to survey patients (maybe one or two wards chosen as test sites) although here too there is the danger of inaccurate or insufficient information, as well as the danger of creating patient expectations that cannot be met with current programs.

Finally, the literature (particularly nursing) can be searched for relevant work by others. Articles abound and some common questions emerge. These, at least, are areas of high patient concern:

What are the changes in my condition? Why?
Why am I taking these medications? What can/will they do?
Will this recur? What's the prognosis?
What activities can I resume after discharge?
What's my real diagnosis? Am I being told the truth?
What's the exact nature of this operation?
Do I need to alter my personal hygiene program?
Must my diet change?
What about impact on personal, family, marital relations?
What are the roles of various staff people?
How will my finances/livelihood change?
Why all these tests?

The staff's perceptions of patients' needs can also be identified a number of ways. Select staff (perhaps chosen after identifying major diagnoses/surgeries) can be interviewed. The perceptions of nurses are particularly valuable since patients tend to spend more time in discussion and venting concerns with them. Ask for examples, try to

elicit what terms the patient used rather than the jargon it was translated into. Use a planned interview form and take notes -- the interviewee needs assurance that this will be accurately recorded. The interview is an excellent opportunity to share your concerns and identify resources.

The staff interview is also an excellent time to begin assessing the staff's educational needs. Do they want more materials to prepare themselves for their roles as program designers? Do they feel up-to-date in their field? Do they want information on teaching styles and materials?

Patients' education needs can also be assessed by committees. Many hospitals have multidisciplinary committees for specific diseases such as diabetes, coronary disease, and chronic obstructive pulmonary disease. Where such committees already exist, chances are that they have already researched needs and can share much with the librarian. Working with a single disease centered committee is an excellent, manageable way to begin library support of patient education.

The needs of the patient and family can also be identified during the initial nursing interview upon admission. This is an excellent, formal opportunity to elicit concerns from patients and their significant others. An obvious problem is that the patient's state of health, level of anxiety, and other family concerns may interfere with good information gathering at this stage, necessitating a postponement of the educational assessment.

The needs of the family are often dissimilar from (or even at odds with) those of the patient. This presents problems both in gathering assessment information, and again later in educational goal setting. Often the family will seek out help from such resources as libraries, social workers, and volunteer agencies as well as from physicians and nurses.

Since interviewing families is a time-consuming process, and generally not practical, other information gathering systems must be found. The initial nursing interview is an excellent time, but requires that the librarian get all information on family needs through a second party.

A library that is open and inviting to family is ideal since it allows first hand information gathering. This unfortunately, is not always feasible. One circumvention might be to allow family telephone access to the medical library. (This differs from access to Tele-Med and other such programs in that it allows dialogue).

Another possibility is to conduct a written survey with the help of nursing staff in which patient/families are asked to identify needs. The involvement of family members in patient care conferences provides another communication avenue.

Contact with agencies and hospitals using programs such as A.A., ostomy clubs, Reach for Recovery, Lost Chord and others can also give much insight into family education needs.

The assessment method chosen is dictated by many practical concerns and therefore may vary greatly from hospital to hospital. What is critical is that no program overlook the fact that a patient is part of a social system which can be either supportive or destructive depending on the quality of education all components receive.

The needs of the staff have been alluded to earlier. Here the librarian has the greatest opportunity for personal contact, observation and assessment. Personnel can be interviewed or surveyed and their borrowing patterns observed. Advisory committees can be formed or joined. Staff needs must be assessed in terms of staff competency to teach given subject materials (up-to-date), staff readiness (self-confidence) to teach, the need for teaching props or support materials, time and staffing constraints and the availability of an evaluation and feedback mechanism.

Once the range of learning needs of patient, family, and staff have been identified, the next stage of assessment begins. With the help of other hospital staff, the librarian must then determine the relative importance of the needs since it is quite unlikely all can be addressed.

The stage requires identification of the decision makers and enablers. Depending upon the hospital's size and politics this may mean the formation of a new committee, working through the Medical Library Advisory Committee, or some similar group which will analyze the data collected, examine existing skills and resources, and set priorities for library support of patient education. A word of fair-warning, committees seem to rarely initiate priority setting and it's a wise librarian who goes into such a meeting with suggestions.

Assessment is absolutely vital, tedious and time-consuming. The 1975 AHA survey summary discussion included this word to the wise:

If a hospital is serious about developing an organized, coordinated program, it should recognize that time must be set aside for assessment and initial planning during the first year. The time needed seems to be approximately 6 - 8 months.

C. Goal Setting

Once the needs have been assessed and priorities set, the librarian must set goals for the library, just as staff and patient must set goals for patient education. In both cases several methods of goal setting can be applied. It must be remembered that goals must be observable, measurable, time-dated, realistic, and evaluated.

Goals for the library (or patient) can be set by calling in outside experts. While this may lend prestige, it often elevates people

and ideas to a level where they seem pedantic and out-of-reach. It is also expensive and may add more time to the process.

Another way to set goals is to survey the needs of one group by using another group. For example, doctors can be surveyed to identify goals for patients, or nurses can be surveyed to set goals for librarians. This method is in fact much used, but presents real problems when the two groups involved lack common terms and understandings.

Yet another way to establish goals is to form (or re-use) a committee. This is also a common mode, and also presents difficulties. Committee results in this area are often ignored because they are so often unsystematic, unrepresentative and non-specific.

Often goals are mandated by legislation, public policy or accreditation requirements. These goals tend to be quite general and are easily influenced by transient whim or pressure.

Goal setting most often fails because no one is given ultimate responsibility. If there is a patient education coordinator designated as being responsible, the library tasks are accomplished largely between that person and the librarian. But, bear in mind that the AHA survey indicated that only a small percentage of hospitals have such a full-time person. It is quite likely that the goals for library involvement in patient health education must be set by the librarian. It is for this reason that so much of this course text has been devoted to such "peripheral" issues as consent, compliance, learning styles, and resources.

Nursing services traditionally have borne the weight of patient education responsibilities, but rarely have had sufficient information and resources to adequately meet their own patient education goals. A well informed librarian working in concert with hospital staff and setting realistic, observable, measurable, time-dated, and evaluated goals will soon find the demands for service growing by quantum leaps.

Setting realistic goals is no easy task. Some can be suggested, but hopefully in each setting unique, responsive goals emerge. Some may set a goal of providing weekly films for closed circuit television; some may choose to build a pamphlet collection; others may choose to equip a mobile cart with mixed media on one disease; others may install a telephone-tape service.² Whatever is chosen will have a greater chance of success if it is built on solid assessment of need.

One final word on goals...don't keep them secret. Goals must be communicated to all concerned - and understood - if they are to be accepted and met.

D. Selection of Methodologies

After goals are set, appropriate educational methods must be selected. This process will involve the selection of materials, methods, teachers and delivery systems. The selection of materials will be

covered in greater detail in another chapter as it is a major library concern. Depending upon the level of library involvement in the total patient education program, other elements will demand varying degrees of attention.

One guideline which applies at all stages of this selection process is that no single person can make methodology selections. A cooperative effort by a team of professionals working with accepted criteria is much more likely to be implemented and succeed than any one person's effort.

Criteria for selecting educational methods should include effectiveness, efficiency, adequacy, and appropriateness. Effectiveness is a relative measure of the extent to which an activity meets a goal.

Efficiency is related to the amount of resources a method utilizes. Such factors as staff, time, dollars, and materials must be considered. Obviously the method which meets a goal using the least resources is the most efficient. (It may not be the most exciting).

Adequacy is the extent to which a method achieves a goal. Many goals cannot be met by just one methodology - a blend and balance are required and the relative benefit/cost of each alternative must be weighed.

Appropriateness is a measure which takes into account the unique nature of each client. It is this concern for appropriateness which necessitates some understanding of how people learn. Materials, sites or teachers which appear sparkling and glamorous to one may be totally unappealing to another - and therefore useless.

Bearing these criteria in mind, the health care team must help the librarian identify and select methods which will enable meeting program goals.

One of the first concerns should be to identify what mechanisms, programs and people are already available to enable library involvement. Can local community resources be utilized? Has someone on staff already assembled a pamphlet, audiovisual, or book collection?

The selection of a delivery system is a major concern. It may entail such things as flow-charting patient's hospitalization to identify teaching times and locations. It may involve identifying secure locations for equipment and materials on wards. It may require securing volunteer staff to escort materials and hardware from library to teaching site. There are no ideal delivery systems, what counts is what works efficiently, effectively, adequately and appropriately for a given situation.

A brief words on the selection of teachers. The best teacher is the one the client patient accepts and who meets the criteria listed earlier. Closed circuit television, machines, books, pamphlets aren't teachers per se, but for the patient who accepts them, they can serve well. What must always be designated is a person who will

accept responsibility for follow-up with the patient after media input. Usually that person is a physician or nurse, and obviously that person must be familiar with the materials the patient has used and the response the patient has had. It is this person who will work with the patient to bridge the gap between information and behavioral or attitudinal change (education). This is why a health team approach is so crucial - to provide a feedback mechanism that works for the patient, as well as allowing more efficient use of staff time.

If the library becomes an information site for planned health education, some formal feedback device must be found. It can be a consultation sheet, memo, a note charted on nurses progress notes (by the librarian if necessary), or some similar method uniformly applied. Informative feedback to staff is a sure way to allay fears about "non-professionals doing patient education."

Ideally, the selection of educational methods occurs in a mutually supportive and flexible setting. This step in the process is likely to be the one in which there is the most need for continual staff education and discussion.

One additional word about CCTV - no media "teaches" - some are more flexible, inexpensive, or readily available than others. Patient programs on CCTV must be totally integrated into patient care to be "educational". That is, the patient must be actively referred to specific programs, have viewing documented, and most important, have an opportunity to ask questions, discuss problems and plan changes.

E. Program Delivery

The fourth step is to carry out the program. Open the doors to the library, begin cart service, or begin showing films. This is the step that is the most distinct, although it is part of a continuum that should not be segmented.

There are books and courses that one can rely on for help with marketing and publicity. As has been mentioned, goals must be shared and understood to be accomplished. Publicize things thoroughly with staff -- be prepared to see continual publicity efforts consume a large proportion of your time. Try every trick in the book and invent a few...and then share them with other harried librarians.

F. Evaluation

The fifth step is fifth only because something must be. It is really not a distinct step that comes at the end. Evaluation must be planned from the beginning. The assessment process must be evaluated all along, goals and delivery must be evaluated. And finally, the evaluation mechanism must itself be evaluated.

To be most useful evaluation must be done by all concerned parties -- patients, family, and staff. Evaluation can be informal conversations or observations. It can be done with paper and pencil surveys, rating

sheets or post-tests. It can be done by individuals, committees, teams or outside experts. It can be done with statistics: Is circulation up? Are inappropriate clinic visits down? Are staff referrals up? Is the library at Highstitch Hospital doing something more efficiently? Is Ms. Helpful at Mt. Painless Hospital getting more funding for materials? However it's done, evaluation must be done, and it must yield useful information for the health care team. Evaluation then, must be planned at the beginning. It must examine the stated educational goals; it should be constant and carried out by everyone involved in the program -- cooperatively.

Evaluation probably causes more difficulties for program planners than any other component of the process.³ It is a subject in which a wealth of literature is developing. Lawrence W. Green, at the Johns Hopkins University School of Hygiene and Public Health, has provided a great deal of guidance in this area. In the Spring and Supplemental May, 1974 issue of Health Education Monographs he offers some suggested designs for evaluation and cost benefit analysis. He also identifies a major problem for program planners in the paucity of standardized measures of health education input and outcome variables. This means that librarians and others in the health education field must work to develop reliable evaluative measures. This is one area in which it would be greatly beneficial to begin formally sharing program and outcome data.

NOTES

- ¹ Marian Adcock, "The Rationale and Application of a Needs Assessment in Patient Education," Patient Education: An Inquiry into the State of the Art. W. Squyres, ed. (New York: Springer, 1980).
- ² Marjorie H. Bartlett, "Patients Receive Current Concise Health Information by Telephone," Hospitals 50(1976): 79-82.
- ³ L. W. Green, "Evaluation and Measurement: Some Dilemmas for Health Education," American Journal of Public Health 67(1977): 155-61.

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CHAPTER VI.

A. Costs and Reimbursements

Of increasing concern to health educators and health care setting administrators are the issues of patient education program costs and reimbursement. The AHA surveys in 1975 and 1978 had made it clear that there were problems with health educators' lack of financial expertise, and with disagreements over the structure of third-party financial arrangements. In 1979 the AHA was supported by the Bureau¹ of Health Education in holding and publishing a Reimbursement Forum.

One significant outcome was distinguishing between patient education and community health education, therefore giving rise to potentially different financing mechanisms for the two. Several speakers emphasized the need to control costs by providing education on an out-patient basis as much as possible. Of course an emphasis on out-patients will require significantly different resources, delivery and documentation systems than in patient programs. Librarians must be sure that their resource development parallels the intentions and needs of the hospital in this area.

Although the Forum reinforced the multiplicity of professional roles, there was a clear message that patient education cannot be simply absorbed as yet another duty by the current work force in most settings. It therefore requires budget consideration for people, work sites, materials, support services and equipment. These additional costs must then be passed on to those paying for medical care.

Brandon Milton, ASHMET society director, identified four rationales for reimbursement of patient education in his Forum testimony. They were:

1. Consideration of patient education as another form of medical treatment not unlike medications and other consumables.
2. The compelling sense that patient education is a significant element in overall medical care cost containment.
3. The reduction of risk, claims, and malpractice litigation that can be expected when a well informed patient takes part in his/her health care.
4. The humanitarian arguments for the benefits of reduced pain and suffering.

He, and many others, argued that without the sound financial underpinning and incentives of reimbursement, patient education efforts will only stumble along. The cost-effectiveness of health education has been a topic for much conjecture and study. Referring back to the discussion of compliance, one can see that cost/benefit concerns are becoming critical in determining where compliance is a valid issue in identifying goals and priorities. By the same token, determining

which health education programs should have priority² will be dependent upon a careful weighing of cost and benefit.

Some persons may be dismayed by the economic motivation, hoping for more humanitarian reason for the upsurge of interest in patient education, but the economic argument is in itself the sum of qualitative issues - social priorities, access and quality, and the general failure of³ medical care to improve the status of community health.

Regardless of the priorities one identifies for a particular hospital's program, there is ample evidence that well thought-out patient health education programs are capable of saving patients, and care-givers, money.⁴ Victor Fuchs, a health economist writes, "Health care is a labor-intensive (effort) and therefore to reduce costs one must instill more personal health skills."⁵ Because good health benefits require longitudinal study over many years, much is yet to be defined.

When the National Commission on the Cost of Medical Care submitted its summary report in December 1977, it made forty-eight recommendations on policies designed to help meet cost containment goals and provide direction for future research. Three of the recommendations dealt with consumer and patient education. The recommendations were:

1. That patients be educated as to costs and benefits of alternative courses of treatment
2. That voluntary health agencies and private sector organizations be encouraged to experiment with health education programs and to provide a national clearinghouse for pre-packaged programs
3. That healthful life styles be encouraged.

Various legislative supports have been offered to provide some impetus for action. The 1973 HMO legislation, required health education programs of health maintenance organizations which sought federal funding. The National Health Education and Promotion Act of 1975 funded the National Center for Health Education and included in the Center's tasks the evaluation of health education effectiveness and efficiency (often measured in dollars) and the attempt at coordination of expensive resources.

Statements of the AHA, Blue Cross Association, (see readings) Social Security Administration and U.S. Dept. of Health Education and Welfare indicate that "patient education is an integral part of patient care."

Third party payers argue that since patient education is integral to basic patient care, it is already reimbursed through basic day rate or per diem charges and therefore separate payment would constitute double payment. With the current emphasis on cost-containment, it is

very unlikely that room rates can, or will, be raised to fully cover patient education.

The incorporation of patient education costs into the basic day rates presents problems for some educators. First, they argue, some patients require a great deal of education, others considerably less, so costs may be unfairly distributed. Second, some educational modes cost less than others (i.e. groups cost less than private consultation) and patients might be (or feel) coerced into taking the least costly mode rather than the most appropriate one. Finally, some types of education require demonstration or expendable materials which add to the cost, while other "classes" might require nothing. None the less, many other educators argue that most patients have nearly equal needs and that the cost discrepancies would be outweighed by efficiencies achieved with simple bookkeeping.

In hospitals where a person has been hired specifically as a patient educator who sees patients on a referral basis, separate charges can be made and paid by the patient. This creates a need to be a profit center which then becomes quite limiting in terms of availability of educator time and outreach. What often goes undone then are the coordinating activities necessary to a truly broad based program.

Insurance carrier's reimbursement and Medicare payments vary widely from situation to situation and state-to-state. All of the insurance carriers a hospital deals with will have to be queried very specifically about separate charge reimbursement, and even then it is likely to remain a subject with great gray areas.

An excellent overview of a reimbursement strategy is given in the Nordberg article cited at the end of this chapter. Clearly a united, concerted push by all the concerned hospital departments must be made (often to more than one insurer at a time) if coverage is to be extended to education programs.

Whether or not charges are repaid is a significant issue for librarians as well as other health education staff because good patient education programs and their development are often quite costly. There are costs for staff, space, materials, and much more. These must be clearly identified as part of the needs assessment stage of the program planning process, and financial commitments must be made.

B. Library Cost Considerations

What follows are some of the cost considerations the librarian must address. Depending upon what support services are available locally, and how library costs are budgeted, unique needs will evolve.

Space

1. Do you control enough space to meet your goals -- or can you get more?

2. Are your departmental costs going to go up if you must make space (for example, will you have to buy more micro format journals?)
3. Does the space available afford privacy for patients and family and security for materials and equipment?
4. Can it be remodeled for multipurpose use?
5. Does it meet fire and building codes for group use?

Facility

1. If you have space and plan to designate a patient education area, will it require remodeling? What will be displaced during remodeling?
2. Consider current door widths, lighting, floor covering, furnishings, placement of electrical outlets, need for improved access (ramps, etc.) within the building.
3. Will you be displacing other patrons?
4. Do you have adequate storage for 5 years of growth and expansion?

Equipment

1. Do your goals require more carts for portable programs, carrels, audiovisual hardware?
2. Will you have to pay for repair contracts?
3. Is equipment durable and compatible with other pieces in your setting?
4. Will you have to build or buy a secure storage area?
5. Can equipment be moved from place to place readily?
6. Is it easily operated by untrained users?

Materials

1. Do you expect to give away materials? (pamphlets are rarely free now)
2. Will you need multiple copies of books, charts, AVs to meet needs of clinics or sub-stations?
3. Will you buy models, posters, or display materials for long term loans?
4. Can you borrow free materials from schools, universities, public libraries or locate sources of free pamphlets?

5. Can you get free or gift subscription through auxiliaries?
6. Will you need to copy materials? Will patients need access to a photocopier?
7. If patients must pay for materials how will the library be reimbursed?
8. If your chosen delivery method is CCTV will you have to pay rentals or royalties?

Materials costs are a major concern for many librarians. Rough figures may help project budget needs here.

Pamphlets - These are heavily used by patients, family members, interested lay people. Although the per person costs can be quite low, high volume makes this very expensive. Anticipate costs of about 25¢ per pamphlet if you buy in quantities of 100 or more. Some "consumables" cost up to \$5.00 but offer full workbook style coverage of topics such as heart attacks, diabetes, and hypertension.

Pamphlets also require an amazing amount of storage space and some type of easy access storage container. All of this contributes to their surprising costliness.

Books - Lay health materials range from \$2.95 paperbacks to \$25 - \$30 encyclopedias and atlases. Local bookstores may be willing to offer a discount. Be sure to take into account the material and staff costs of processing and circulating book materials. (They need sturdy plastic covers, etc.)

Journals - Some of the major journals costs for 1981-82 are as follows:

Medical Self-Care - \$15/year

Health Education Quarterly - \$48/year for institutions

Health Education Monographs is continued by Health Education Quarterly

Health Education Journal (British) £3/year (approx. \$7.50)

Patient Counseling and Health Education - \$38/year for institutions, \$19.50 for individuals

Self Care Reporter - \$10/year

Consumer Health Information Newsletter - free

Other journals, of course, should be considered including "women's" journals and general lay level journals with regular health issues coverage.

Audiovisuals - Assuming you are purchasing (rather than renting or leasing) AVs the following cost guidelines (1981 estimates) may help. On the average:

Videocassette - \$150-\$300/30 minute program

Slide/tape - \$95-\$150/program

Audiotapes - \$10-\$40/tape

Models - \$50-\$150/model

Charts - \$5-\$200

Staff

1. Do you have any to spare?
2. Can you get volunteers to escort materials from library to teaching sites?
3. Will someone have to stay with family members or patients while films or other material is shown?
4. Do you have time to catalog materials or will you purchase cataloging?
5. Will you have to change/extend library hours?
6. Who will be responsible for documentation?

Intermingled in all the patient education cost considerations are concerns with the additional costs incurred when staff education and update needs must be met. You may need to set aside money for a special staff support collection strong in program examples and education texts.

Some resources to offset costs have been identified already. In addition some audiovisual programs currently available for purchase are products of grants from foundations and industries such as the Robert Wood Johnson Foundation, the Public Broadcasting Corporation, Abbott Laboratories, Exxon, the 3M Company and others. Hopefully such underwriting of programs will continue as public services to provide high quality materials at reasonable costs.

In some communities, private donations and endowments keep a hospital patient education program well funded. This takes a tremendous public relations effort, but may be an excellent source.

A similar resource may be the hospital's auxiliary. Here one may expect to find both financial and labor resources. While patient health education is not necessarily an area for volunteer workers; publicizing the program, escorting carts, and physical processing are among the tasks that can be performed well by volunteers. Obviously

too, some very fine patient education programs such as Reach for Recovery, Ostomy, A.A., Lost Chord, Candlelighters, and Overeaters Anonymous make excellent use of volunteer networks.

In some cases help may be sought from local colleges and universities in the planning, materials development and conduct of programs. Many other resources (identified in an earlier chapter) can be investigated. One word of caution, remember the importance of needs assessment -- don't set goals and plan programs just on the basis of what resources are available.

A few final words on costs...Librarians, in concert, can exercise several cost-containment measures. They can use their professional peer network to avoid reinventing the wheel. Share strategies, resources, and if possible, materials. Some regions have developed the circuit-rider librarian concept to provide professional medical library service in settings where a full-time librarian cannot be funded. Might a variation of this help you develop a program? Are consultants a possibility to get a program off the ground?

Working with professional groups, librarians can also begin to require producers of media to provide durable materials at reasonable costs in acceptable formats. The costs of programs have risen significantly, in part because of the perception that it is a seller's market. Pressure can be brought to bear on producers who make exorbitant additional charges for format conversions by professional organizations.

Costs are a very real concern in setting up a patient education program. A wise librarian can secure a place on the health care team by demonstrating that his/her contribution will, in the course of time, save the institution staff, space, and material dollars. It should be remembered though that using the library isn't warranted when it's just cheaper than something else, but when it's more efficient.

NOTES

¹Reimbursement Forum Proceeding, Oct. 25, 1979, available from CDC, BHE. Atlanta, Georgia 30333.

²Lawrence W. Green, "The Potential of Health Education Includes Cost Effectiveness," Hospitals 50(1976): 57-61.

³Lowell S. Levin, "The Layperson as the Primary Health Care Practitioner," Public Health Reports 91(1976): 206.

⁴Ibid.

⁵Victor Fuchs, Who Shall Live (New York: Basic Books, Inc., 1975).

CHAPTER VI - READINGS

1. American Hospital Association. The Hospitals Responsibility for Health Promotion. (Chicago: AHA, 1979).
2. Blue Cross Association. A White Paper: Patient Health Education. (Chicago: BCA, 1974).
3. Health Insurance Association of America. Financing In-Hospital Patient Education: Proposed Criteria (New York: HIAA, 1977).
4. Nordberg, Beatrice and L. King. "Third Party Payment for Patient Education." American Journal of Nursing 76(1976): 1269-1271.

CHAPTER VII.

A. Materials Selection

Perhaps the most familiar, and most troublesome, concerns of librarians will be materials selection, acquisition, organization and control. To attempt any of these traditional library functions in the area of patient education without some non-traditional library education courts frustration. But, at the same time for the librarian not to be involved in these functions, vis-a-vis patient education can lead to inefficient hospital use of space, staff, time, and dollars.

The issues and considerations are many and varied, and the validity of library service decisions made for any given institution will be dependent upon the quality of needs and resources assessments which preceded. The librarian must bring into account a personal understanding of the rationales for patient education, the resources available, the potential costs and reimbursements, and the program needs of the institution served.

Given the impossibility of buying everything available or desirable in patient health education (an all too familiar library bind), it is essential that some selection policy/process exists. Many experienced librarians feel that a written policy lends itself better to examination, reconsideration, and administrative support than an unwritten "understanding". While flexibility is essential, it should be recognized that identifying high quality health education materials for the layperson poses some serious problems for the librarian.

A materials selection policy that is clearly stated and officially adopted is essential in the selection process. It establishes the basic principles and limits of selection and provides policies, procedures, and criteria that are used as a guide in selection.

Policies may be quite specific as to who will review/approve materials and in what areas; or they may make a more general statement such as "using professional review tools and judgement, the librarian selects materials representative and supportive of patient education programs and needs. The advice and consent of knowledgeable health care givers is sought as necessary". Obviously, political realities differ from one situation to another.

Take a few moment to answer these questions relative to the handling of patient materials.

Who currently selects/approves medical library books?
Are they willing to take on additional selection responsibilities?
Are non-librarians currently selecting, acquiring, dissemination materials for patients? (What disciplines?)
Is the acquisition and dissemination effort coordinated at all?
Who controls funds for materials?
Where are materials currently housed?

Who is likely to support/oppose a library role in this regard?
Who must approve your policies?
Who might profitably ally themselves with you?

The timely review of all print materials by a committee seems both unlikely and unnecessary. However, certain health information areas may merit seeking consultation because they are more prone to popularization and unscientific writing. Diet, exercise, and self-treatment materials are particularly problematic. Reviews of materials under consideration can be routed to content experts with a copy of the preview form where questions of appropriateness exist. Indeed, this is an excellent way to reassure hospital staff that the library's commitment is to function as part of a team.

While selection through reviews may be quite feasible for books it is never recommended for audiovisual materials. The costs of the materials are simply too high to risk errors in judgement. Furthermore, since health care practices and resources may vary from situation to situation, it is imperative that materials made available for patient use closely reflect local practice. Finally, it is in the previewing process that most of the medical staff can begin to acknowledge the propriety of library involvement in patient education.

Previewing materials must be a budgeted item because many programs (particularly videotapes and films) are available only for a fee. It might be worthwhile to identify other librarians in your area who are interested in previewing patient health materials and devising a bicycle circuit for sharing previews of the more costly items. AVs are now reviewed to a limited extent in LJ, Choice, Medical Self-Care, Wilson Library Bulletin.

A preview evaluation form is a necessity to insure a uniform approach to materials, and to provide a record. The record can be useful when purchase (or non-purchase) of a program is challenged. It is strongly suggested that all audiovisual materials be reviewed by a multi-disciplinary team. Ideally, members should preview together to facilitate exchange of ideas.

Fixed membership on a review committee is less desirable than the use of subject experts in each area being considered. This is because referrals are most likely to be made when staff people have been directly involved in the selection of materials pertinent to their patients. Potential reviewers include but are not limited to: physicians, nurses, dietitians, occupational and physical therapists, educators, media experts, and instructional designers. Finally, the patient and family must be considered as potential reviewers. While they cannot judge content accuracy, patient assessment of appropriateness, level of interest, aesthetic and informational appeal is invaluable. Patient and families can also indicate what wasn't covered that concerns them.

Another review procedure which is perhaps most useful to sort out poor audiovisual offerings involves sharing reviews with other potential users. Ideally, this should be undertaken as a national clearing-

house program, but for now it may be practical to implement on a smaller scale in a city or regional network, or even between neighboring hospitals. The amount of time and cost involved in surveying the materials even on a limited subject dictates that consideration be efficiently concentrated. Shared, written evaluations can provide some direction and pre-sorting. Obviously, using common review forms and protocols makes this more manageable and meaningful.

Once materials have been previewed, the responses should be collected, collated, and kept as a permanent record both for in-house use and for sharing with other librarians. The producers of patient education materials are too numerous and subject to change and addition to list here. Some resource^{2,3,4} guides exist which can at least indicate the range of producers.

In general, several criteria must be considered in evaluation. They include:

1. validity and accuracy of content
2. appropriateness with regard to audience and program intent
3. accessibility and clearance for use on CCTV, or within a network if appropriate
4. quality of production -- particularly visual and audio
5. appropriateness of format both from the teaching and handling point of view
6. cost

It should be apparent that different criteria are best addressed by experts in those fields. Few librarians will encounter difficulties identifying subject experts...indeed, one may find a plethora of content experts contributing to selection woes. Again, it helps to gather all content experts together for previewing -- let them make a final decision together on over-all accuracy and validity rather than trying to interpret and weigh separate responses yourself.

Audience appropriateness and success are best determined by the intended audience. Where that is not possible (generally it is a problem), the librarian may have to make such judgements with other staff members. It is for this reason that so much attention has been given to examining learner needs.

For print materials, where reading level may be of concern, standard reading level formulae may be applied.

Where budgets are small or special controls exist, materials may have to be borrowed or rented either on a fixed schedule or as needed. In those cases special arrangements with lenders or fiscal offices may have to be made ahead of time. Where closed circuit television is to be used this should be explained to the lender or seller of

audiovisual materials. Some suppliers of commercial health education materials promote their programs especially for CCTV systems, while others forbid CCTV use without payment of additional fees. Similarly interlibrary loan arrangements must be considered.

Audiovisual programs add variety (pizzazz) and breadth to many patient education efforts. The 1977 AHA survey on inpatient education indicated that 92 percent of the responding hospitals relied on one-to-one teaching with print media as the most common resource. Next in use were filmstrips, films and flipcharts, with 23 percent using videotapes. The use of media is limited by lack of funds, lack of familiarity and concern as to the efficacy of that style of information delivery.

Unfortunately, there is still very little evaluation of such special areas as CCTV available to aid health education planners.

The lack of developer expertise in human behavior is quite apparent in many media programs. Too often bits of information are arrayed in a media patchwork which does little to involve the patient in health care decision-making. The attractive packaging and entertainment qualities must be carefully sorted out from educational qualities. A well designed review form can aid previewers in doing this.

Even the simplest elements of audiovisual quality should be carefully assessed. Programs are often too quickly paced for comfort; labels and graphic materials may not be sufficiently clear (or may contribute unnecessary clutter). Graphics may date materials with too much detail in clothing, cars and hairstyles. Or the graphics may be gratuitous and not clearly reflect script. In assessing sound tracks one should remember that as adults age, they experience loss of hearing acuity for sounds at the top of the vocal register, and therefore male voices or low female voices provide better narration quality. Narration that is too fast-paced, accented, garbled, or hindered by background noise should also be avoided. Another concern with audio quality, is the contributing noise of the playback equipment. For this reason, 16mm films in small rooms are often inaudible.

Other evaluative considerations such as intended audience size, location of use, need for professional equipment operators, length of time needed for use, need for staffing during use, intended lifespan of program, must also be dealt with before purchase or rental decisions are made.

For a study of the need for identification of mediated patient education programs for patient educators a brief article written by Mary Heider may be of help.⁶ A limited survey indicates which formats were most used.

In all collections, weeding out-of-date or inappropriate materials is a major concern both to provide space and to maintain a reputable collection. Some librarians include date of production in audiovisual materials call numbers to alert them to aging materials.

While this may be quite useful to pre-sort materials for consideration, it cannot be easily used as a weeding criterion since all areas of concern advance at different rates. Ideally, staff using programs will be familiar enough with materials and state of the art to notify the librarian when the text or illustrations are no longer accurate. Where the staff involvement is such that materials are not regularly scrutinized, it would be wise to prepare a weeding calendar by subject and invite staff to review materials. Here again, a review file with additional notations updating the evaluations can be quite helpful.

Some generalizations and definitions regarding the use of various teaching modes to encourage desired behavioral outcomes are provided by Malcolm Knowles on the following page.

The salient considerations regarding hardware are few. Do you already own, or must you purchase the necessary equipment? If you must purchase something, will it be useful for other programs being carried out in the hospital center or clinic? Equipment unique to one manufacturer or program provider is obviously less desirable than standard equipment. Ease of operation, incidence of repair problems, ease of storage and portability are all important. A significant hardware consideration must be mechanical noise. A clacking 16mm or carousel projector is distracting, and incompatible in areas where several pieces of equipment are used simultaneously or where small rooms don't dissipate the noise. Depending upon room size, program needs and budgets, other considerations become important or imperative.

Print materials must above all else be accurate, clear, and uncluttered. Charts must not be unwieldy or flimsy and should be evaluated both for individual and group use. Shiny finishes on charts and posters may require special lighting or add unnecessarily to bulk weight. The considerations here too are largely dependent upon intended use, storage available, cost, and the likelihood of materials becoming dated.

B. Organization and Control

Once materials have been reviewed and selected they must be made known and available to patrons. The immediate problem for the librarian is to determine who will have access, whether through the card catalog or bibliographies, to materials. If catalog use and borrowing are primarily by staff, classification and subject heading may be quite different from those which would be developed for laypersons. Obviously, cataloging must be orderly enough to be systematic and flexible enough to reflect the unique nature of an institution and its users. If a catalog is to be used by the public such considerations as bilingual subject headings must be made.

Basically, materials can be organized using the Dewey Decimal, NLM, or LC systems. Dewey may be most familiar and comfortable for laymen, but if access is primarily by medical staff or if collections are integrated, it is an unlikely choice.

MATCHING TECHNIQUES TO DESIRED BEHAVIORAL OUTCOMES

<u>Type of Behavioral Outcome</u>	<u>Most Appropriate Techniques</u>
KNOWLEDGE (Generalizations about experience; (internalization) information)	Lecture, television, debate, dialog, interview, symposium, panel, group interview, colloquy, motion picture, slide, film, recording, book-based discussion, reading.
UNDERSTANDING (Application of information and generalizations)	Audience participation, demonstration, motion picture, dramatization, Socratic discussion, problem-solving discussion, case discussion, critical incident process, case method, games.
SKILL (Incorporation of new ways of performing through practice)	Role playing, in-basket exercises, games, action mazes, participative cases, T-group, nonverbal exercises, skill practice exercises, drill, coaching.
ATTITUDES (Adoption of new feelings through experiencing greater success with them than with old)	Experience-sharing discussion, group-centered discussion, role playing critical incident process, case method, games, participative cases, T-group, nonverbal exercises.
VALUES (The adoption and priority arrangement of beliefs)	Television, lecture (sermon), debate dialog, symposium, colloquy, motion picture, dramatization, guided discussion, experience-sharing discussion, role playing, critical incident process, games, T-group.
INTERESTS (Satisfying exposure to new activities)	Television, demonstration, motion picture, slide film dramatization, experience-sharing discussion, exhibits, trips, nonverbal exercises.

Reprinted from:

Malcolm Knowles, Modern Practice of Adult Education (New York: Association Press, 1970), p. 294.

Subject headings are problematic because using one system may eliminate access by an entire patron group. Library of Congress and NLM MeSH headings are well developed but not nearly as familiar to laymen as Sears Subject Headings. Sears, while familiar, is not always specific enough.

One tool librarians may find invaluable for both its professional wisdom and common sense is the publication Technicalities. This provides excellent insight into the current use of health-related terms, indicates the Hennepin County Library (Minneapolis, Minnesota) vocabulary terms and encourages input from anyone interested in hassle-free information access.

Obviously, decisions as to which systems to implement should be made in light of user needs, cost, current cataloging practice and resources, and anticipated development of the collection.

Ideally, cataloging should be done with an eye to making collections known and possibly available for loan through library networks. The practical concerns of this topic should be considered by consortia and library groups thinking of doing any sharing before too many fragmented approaches are pursued.

Few librarians need much proselytizing with regard to the existence of departmental collections. They are particularly discouraged for patient health education collections. Materials are costly, rarely unique to a ward (even maternity, dental, and child care materials), and often in need of constant re-evaluation and maintenance. It is too difficult to maintain accurate inventory or satisfactory control over physical location when each department or ward attempts to be self-contained. Departmental collections are easily begun and almost impossible to dismantle -- therefore, the librarian must make strong and logical arguments against them before the first seed (or film) hits the ground. Here again, a written policy endorsed by administration may be most helpful. Certainly if library funds are being tapped, a written policy is a must.

C. Copyright Concerns and Acquisition

A final concern in selection and organization has to do with problems imposed by copyright law. Audiovisual materials are notably fragile and expensive -- unfortunately, copies duplicated for safety files without written permission are illegal. At the least, this means libraries must exercise strict control over the handling and usage of materials. At the worst, it may preclude interlibrary loans of expensive materials or dictate costly duplicate purchases. A few producers will sell second copies at reduced rates, but most are holding fast to one price - one copy. Many producers are now attempting to forbid interlibrary loans as a way of ensuring a market. Often this is done by requiring a limiting purchase agreement. In practice of course this is hard to police. More importantly, these limits strike at the heart of library cooperation. It has been helpful to submit purchase orders which predicate purchase upon freedom to loan or broadcast on CCTV. This can be accomplished with a one line state-

ment on the order such as: "purchased with the understanding that this will be used on CCTV...and/or lent as any other library materials".

Another copyright concern arises with alteration of format. Many producers are making materials available on only one format - which for a variety of reasons may be inappropriate for a given collection. Some producers will give written permission to allow purchasers to alter format and thereby have an additional copy. Since many hospitals do not have sophisticated medical media production facilities available, this can be a limited concession. As librarians make their format limitations and needs known, producers will hopefully become more responsive. This is an excellent arena for the development of a cooperative consumer movement. Here again, the need to alter format can be made a condition of purchase with a statement such as "purchased with the understanding that 1 videocassette copy will be made from the 16mm film for in house use only". Generally, changed format copies should not be lent.

In many hospitals there is tremendous pressure from doctors and nurses to produce materials for local use. Of course it is often necessary after surveying available materials, but it should never be undertaken without careful evaluation of existent materials. The librarian, by serving on a multidisciplinary patient education committee, can help keep such projects to an economical minimum. And certainly, whenever such materials are produced they should be cataloged, and hopefully housed in the library patient health education collection.

A brief orientation program on the use of media in patient education may be advisable for use with patient education committees. Some materials are available from AHA and a number of other sources for those interested in media development.^{8,9}

All media work us over completely. They are so pervasive in their personal, political, economic, aesthetic, psychological, moral, ethical and social consequences that they leave no part of us untouched, unaffected, unaltered. The medium is the message.¹⁰

Even the most sympathetic librarian involved in hospital-based patient education may well argue that the medium is much more rub than massage.

NOTES

- ¹Warren B. Hicks and Alma M. Tillin, Managing Multi-Media Libraries, (New York: Bowker, 1977), p. 139.
- ²Joan Ash, Health: A Multimedia Source Guide, (New York: Bowker, 1976).
- ³Alan Rees, Consumer Health Information Sourcebook, (New York: Bowker, 1981).
- ⁴Source List for Patient Education Materials, 1978. HeSCA (2343 N. 115th St., Wauwatosa, Wisc. 53226).
- ⁵Readability Testing in Cancer Communications, NIH publ. no. 79-1689. Reprinted June 1979. Office of Cancer Communications, National Cancer Institute, Bethesda, MD 20205 (free).
- ⁶Mary Heider, Biomedical Communications, (November, 1977).
- ⁷1982 cost \$36.00/year (institutions); \$24.00/year (individuals) Onyx Press.
- ⁸Communicating Your Message. 80 slides with guide. The Media Tree, 1981 (#452) (preview available).
- ⁹Jerrold Kemp, Planning and Producing Audiovisual Materials, 4th ed. (New York: Harper and Row, 1980).
- ¹⁰Marshall McLuhan, The Medium is the Message, (New York: Bantam Books, 1967).

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2. Kemp, J.E. "Which Medium." Audiovisual Instruction (December, 1971); p. 14.
3. Lazes, Peter M. Handbook of Health Education. Germantown, Maryland: Aspen, 1979.
4. Manning, Diane. "Writing Readable Health Messages." Public Health Reports. 96: 464-5.
5. Melrose, J. "Audiocassettes Help Hospitals Break Language Barriers to Care." JAMA, August 22, 1977, p. 878-9.
6. Schramm, W. Big Media, Little Media: Tools and Technologies for Instruction. Beverly Hills, California: Sage, 1977.
7. Squyres, Wendy. Patient Education: An Inquiry into the State of the Art. New York: Springer, 1980.
8. "Audiovisual Showcase." Library Journal 107 (1982): 61-82.

Summary

Medical librarians have joined with health care providers from myriad professions in expressing their concerns that the health information needs of the American public be met in a systematic, productive way. Clearly no one system has been demonstrated to offer the definitive role for medical librarians. Each librarian must seek out a role which incorporates a solid understanding of needs and mandates, while at the same time being tailored to the stark realities of limited resources. It is a constant struggle to remain sufficiently "tuned in" to local and national developments while serving in an already full-time job. Nonetheless, the medical librarian is a necessary and generally welcome member of the health care team, and the rewards of participation are great.